THE PRIMARY HEALTH CARE SYSTEM IN FIJI

A PRIMARY HEALTH CARE PERFORMANCE INITIATIVE ASSESSMENT

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WORLD BANK GROUP
Health, Nutrition & Population

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Report prepared by the World Bank in consultation
with the Ministry of Health and Medical Services, Fiji.

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This report presents the key findings of the Primary Health Care Performance Initiative (PHCPI) assessment in Fiji, which World Bank team led by Manuela Villar-Uribe and Margareta Norris Harrit completed in collaboration with the Ministry of Health and Medical Services of Fiji. Lucy Hartshorn led qualitative data collection and analysis with support from Mesulame Namedre and Rachel Fotofili. Caitlin Noonan led quantitative data analysis and curation. Lucy Hartshorn led report writing and coordination, and Caitlin Noonan, Awa Diallo, and Cameron Feil provided writing support. Ann Shildneck provided editorial support. Diego Hernan Vapore provided design support. Baldeep Dhaliwal, Dr. Sam Fullman, Dr. Eric Rafai, Marwa Ramadan, and Valeria Cruz Villaba provided critical input at different phases of the assessment (listed alphabetically).

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ABBREVIATIONS

ANC	Antenatal Care
ART	Antiretroviral therapy
AYF	Adolescent and Youth-Friendly
BCG	Bacillus Calmette–Guérin vaccine
CBS	Community-Based Surveillance
CHW	Community Health Worker
CMRIS	Consolidated Monthly Return Information System
CRAMP	cardiovascular risk assessment and management protocol
CRVS	civil registration and vital statistics
CSN	Clinical Service Networks
DALY	Disability-Adjusted Life Year
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
DPT3	Diphtheria-pertussis-tetanus, third dose
DRF	Drug Revolving Fund
EWARS	Early Warning and Syndromic Systems
FMIS	Financial Management Information System
FP	Family Planning
FWCC	Fiji Women's Crisis Centre
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GGHE	General Government Health Expenditure
GHED	Global Health Expenditure Database
HIES	Household Income and Expenditure Survey
HIV	Human Immunodeficiency Viruses
HMIS	Health Management Information System
IDSR	Integrated Disease Surveillance and Response
IHME	Institute for Health Metrics and Evaluation
MCH	Maternal and Child Health

MICS	Multiple Indicator Cluster Survey
MHMS	Ministry of Health and Medical Services
MOH	Ministry of Health
MWCPA	Ministry of Women & Children and Poverty Alleviation
NAP	National Action Plan
NCD	Noncommunicable Disease
NGO	Non-Governmental Organization
NNDS	National Notifiable Disease System
NSAP	National Strategic Action Plan
NSP	National Strategic Plan
OOPS	Out-of-Pocket Spending
ORS	Oral Rehydration Salts
PATIS-plus	Patient Information System
PEN	Package of Essential NCD Services
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PHIS	Public Health Information System
PMTCT	prevention of mother-to-child transmission of HIV
PPP	Purchasing Power Parity
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SARA	Service Availability and Readiness Assessment
SBA	Skilled birth attendance
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health Rights
STEPs	STEPwise approach
STI	Sexually Transmitted Infections
TB	Tuberculosis
UHC	Universal Health Coverage
VSP	Vital Signs Profile
WHO	World Health Organization

EXECUTIVE SUMMARY

This report presents the findings of the Vital Signs Profile (VSP) assessment conducted by the World Bank and the Primary Health Care Performance Initiative (PHCPI) in collaboration with Fiji's Ministry of Health and Medical Services (MHMS). The VSP provides an opportunity to assess the state of the primary health care (PHC) system in Fiji, highlighting areas of strength and challenges through the lens of the PHCPI framework. The framework organizes various domains and subdomains of primary health care using a logic model approach that encompasses the traditional inputs and outputs of PHC systems and emphasizes the capacity and processes of PHC service delivery and performance (Bitton et al. 2017). Notably, while PHCPI recognizes the role of social determinants of health and intersectoral health promotion and prevention efforts as important factors influencing population health, the VSP is primarily focused on aspects of health service delivery. Fiji is one of four Pacific countries—alongside Kiribati, the Republic of the Marshall Islands, and Solomon Islands—that have, with support of the World Bank, used PHCPI tools to take stock of current performance, safeguard what works well, and lay out a vision for areas requiring improvement.

PHC performance is evaluated in terms of access, coverage, and quality. There have been significant shifts over time in the service coverage and effectiveness of PHC delivery. Service coverage is assessed for reproductive, maternal, neonatal, and child health (RMNCH), infectious diseases, and non-communicable diseases (NCDs). RMNCH service coverage has declined since 2015, particularly in antenatal care and family planning satisfied with modern methods. There are gaps in the treatment of childhood diarrhea and HIV and in the detection and treatment of tuberculosis. The coverage of non-communicable disease (NCD) services, including hypertension treatment, is low and requires attention as NCD prevalence increases. These findings highlight the need for comprehensive strategies to increase service coverage and reduce disparities in access to essential health care, especially as it relates to the affordability of medicines.

PHC quality measures examine health care comprehensiveness, continuity, person centeredness, provider competence, and safety practices. There are gaps in delivery of comprehensive care for various health conditions, particularly NCDs, infectious disease, and RMNCH. Although services for certain NCDs are relatively well-provided, RMNCH services are less comprehensive, and communicable disease services need improvement. Care provision varies at different levels of the health system and between urban and rural settings, highlighting disparities. Patient safety practices, particularly in infection prevention and control and waste disposal, need to be improved. The analysis underscores the need for ongoing data collection to assess provider competence, person centeredness, and provider availability, which are lacking, and emphasizes the importance of enhancing person-centered care to increase patient satisfaction and improve overall health care outcomes.

Fiji's pursuit of equitable PHC coverage and access is essential to reduce disparities in health outcomes across its population. Disparities between urban and rural populations are evident in financial barriers to care, with rural areas experiencing higher rates of financial deprivation related to medications. There are differences in antenatal care and demand for family planning based on the level of a mother's education. The analysis also highlights disparities in infectious disease and nutrition coverage according to division[1] and wealth quintile, affecting the overall health of the population. Inequities in PHC access and coverage affect key population health outcomes, leading to variations in under-five mortality rates based on residence, division, mother's education, and wealth quintile. These findings underscore the significance of addressing health disparities by ensuring equitable health care access and outcomes for all Fijians.

The capacity of PHC in Fiji is evaluated in terms of governance, inputs, and population health and facility management. Measures of capacity demonstrate important strengths, as well as areas of opportunity, related

1 Central, Eastern, Northern, Western.

to the foundational properties that enable a system to deliver high-quality PHC. Fiji has a strong foundation for current efforts to revitalize PHC due to its history of having a PHC-oriented approach. However, there is no explicit or shared definition of PHC in Fiji. Challenges lie in the different interpretations of primary health care in action, compounded by lack of coordination at the national level. Authority for PHC is divided between MHMS programs and divisions, which contributes to fragmentation and confusion in the scope of PHC strategies despite PHC being well integrated at the facility and service delivery level by front-line health workers. The health system has mechanisms to support its adjustment to population health needs, including a surveillance system that has benefited from recent investments. There is opportunity to support the priority setting process through greater use of data in establishing priorities and involvement of stakeholders at various planning and priority-setting levels from a PHC rather than a programmatic perspective. An emphasis on access to health facilities has contributed to the current density and distribution of health facilities across the country, including remote and hard-to-reach areas. Although there are facilities across the country, facilities' locations are not well aligned with population densities, leaving urban areas with few PHC facilities and limited health workforce to serve large catchment populations. The large number of facilities also creates resource constraints that can be seen in low numbers of facilities with access to necessary amenities and safety equipment. The availability of health workers remains a salient and important challenge to achieving universal, high-quality health services, despite allocated financing that would allow for recruitment of sufficient workforce. Challenges in workforce retention contribute to this. Additionally, gaps in systems and processes to support population health management and facility organization and management represent an area of opportunity to drive performance improvements.

The financing domain of the VSP evaluates a country's financial commitment and spending prioritization towards PHC using five key indicators. The WHO's Global Health Expenditure database reports that

Fiji has shown an increase in per capita spending on PHC, from US$112 in 2016 to US$144 in 2019. In 2019, 63 percent of all current expenditure on health was allocated to PHC, and out-of-pocket expenditure decreased significantly from 2016 to 2019.[2] Public expenditures are the primary source of PHC financing, with a slight increase in government contributions as a percentage of overall PHC funding, while private contributions have decreased, and external sources have played an increasing role in total PHC spending.

The following recommendations have been developed to address the challenges identified and to support Fiji's efforts to revitalize PHC and achieve universal, effective PHC coverage. Considering the VSP's focus on delivery of health services (which forms the basis of the recommendations), it is also important to note that efforts to strengthen the health system must be accompanied by efforts to strengthen health promotion and prevention from an equity lens, particularly to address the substantial and growing burden of NCDs and ensure sensitivity to gender concerns in delivery of services.

1. **Implement a people-centered model of care focused on delivering comprehensive PHC at the community level by updating the package of health services and redefining the next generation of PHC personnel.**

   Fiji could develop a comprehensive package of services, improve the competencies of PHC personnel, reallocate the workforce in alignment with population needs, and revisit competencies for service-delivery teams. Formulating a PHC service package and training health care providers to deliver the service package will be essential steps toward promoting comprehensive, competent, and equitable PHC for the population in Fiji.

2 Global Health Expenditure Database. World Health Organization, Geneva, Switzerland (accessed November 2023), https://apps.who.int/nha/database.

2. **Enhance community-based services by bolstering proactive population outreach efforts and fortifying the Community Health Worker (CHW) program.**

   To enhance community-based services and strengthen Fiji's CHW program, proactive population outreach strategies could be reinforced and the scope of services that CHWs deliver expanded. Proactive population outreach, which involves health care providers offering care in homes or communities, can be expanded to include integrated preventive measures, health education, identification of acute cases, and family planning services, all initiated by the health system. Fiji could further leverage proactive population outreach efforts to ensure appropriate implementation of population-wide screening of children and youth through the revised Healthy School Policy and measure its success in preventing and managing disease. In addition, mobile clinics could be employed to extend service distribution, especially in underserved areas. The relationship between mobile clinics and under-utilized facilities should be strategically assessed to achieve a balanced and efficient provision of services. This involves considering the deployment of mobile clinics in areas with underused facilities in addition to use of mobile clinics alongside facilities for improved outreach. CHWs could play a pivotal role in task shifting, taking on expanded responsibilities to bridge the gap between health facility locations and the population. Proper training, accreditation, remuneration, and integration into health management information systems are essential for effective use of CHWs, ultimately ensuring equitable access to high-quality care. Collaboration with the Ministry of iTaukei Affairs can further enhance the reach and cultural sensitivity of CHW services.

3. **Strengthen governance and leadership for PHC for effective prioritization and implementation of comprehensive PHC as part of**

a broader effort to enhance accountability for achieving collective health system results.

The MHMS organizational structure has become increasingly dense with vertical programs in the past decade. Fiji could enhance the clarity, coordination, and collaboration around PHC by establishing a senior PHC leadership position within the Ministry of Health and Medical Services to collate existing but fragmented PHC efforts across national and divisional levels. This could be part of a broader reorganization within the MHMS to reduce duplication and enhance accountability for achieving clearly defined health objectives and targets. Strong leadership enhances the effectiveness of policy planning and implementation and ensures comprehensive PHC by coordinating across units and divisions. PHC leadership can also facilitate accountability for PHC by populating monitoring and evaluation frameworks with performance data, hosting regular reviews to track progress, and publicly disclosing the status of PHC. Establishment of a designated PHC committee and annual multisectoral meeting, which PHC leadership would champion, would also strengthen collaboration and coordination between the MHMS and other important PHC actors and stakeholders.

4. **Leverage the recently approved digital health strategy to enable regular analysis and application of information on PHC capacity, performance, and outcomes at facility, subnational, and national levels.**

Building on investments in information systems, Fiji can leverage existing digital and paper-based information systems to improve key health system functions. Information systems are essential for development and implementation of person-centered care management approaches and for monitoring the quality of clinical service provision. Fiji can enable facility-level analysis of performance and outcome data by investing in nonmedical human resources at the

command center level and supporting the PHC system to coordinate care, monitor performance, and drive effective management. The command centers, established at the subdivisional level for coordination during COVID-19, have the potential to support the health system by taking on nonmedical operational tasks such as data analysis and disease tracking. Further investing in the digitalization of existing information systems at the nursing station level could support seamless information exchange and person-centered care. Integrating information systems, including PATIS-plus, the Consolidated Monthly Return Information System, paper-based personal care records, and Civil Registration and Vital Statistics (CRVS) system, could yield further dividends in health system performance through efficient use of information to deliver high-quality, continuous PHC.

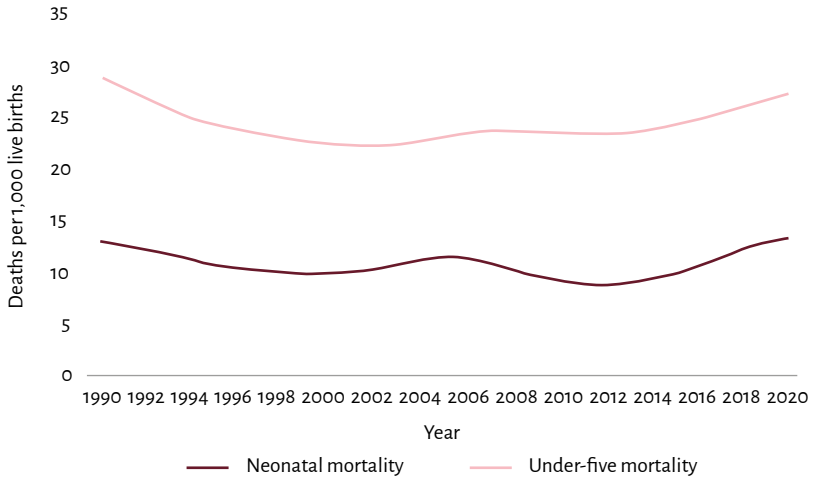
5. **Strengthen and standardize systems for regular community engagement in PHC priority setting and accountability.**

   To promote person-centered health services and community participation in the PHC system, Fiji could standardize processes for community engagement and incorporate routine, person-centered assessments on service quality and coverage. This can be achieved by establishing community health boards or similar structures that involve communities in decision making and resource allocation. Additionally, routine evaluation mechanisms, such as patient exit surveys and observations, could be implemented to gauge quality of services and align them with population needs. With a focus on gender empowerment, Fiji can institutionalize the inclusion of women and girls in decision making, fostering gender-balanced committees and creating safe spaces for open communication and feedback from all community members. These efforts aim to enhance community involvement and ensure that the voices and experiences of everyone, especially women and girls, are considered in shaping Fiji's PHC system.

INTRODUCTION

Although health outcomes improved after Fiji gained its independence in 1970, health indicators have stagnated or declined in recent years. People in Fiji, the most urbanized country in Pacific Islands, are living longer, with life expectancy rising from 65.5 years in 1990 to 70.4 years in 2017 (Fiji Bureau of Statistics 2017). The country has continued to achieve high coverage rates in key services such as immunization, with childhood immunization rates of 96 percent to 99 percent for all doses of required vaccines in 2021.[3] Despite increases in immunization rates since 1990, the under-five mortality rate (U5MR) increased from 23 deaths per 1,000 live births in 2001 to 28 in 2021, and neonatal mortality rate (NMR) increased from 9 deaths per 1,000 live births in 2012 to 14 in 2021 (Figure 1).[4]

Figure 1. Under-five and Neonatal Mortality, Fiji (1990-2020)



Source: UNICEF 2023.

Fiji has a history of prioritizing a primary health care (PHC) approach. Fiji has historically distinguished between "primary health care" and "public health." Primary health care is focused on providing individual and community-based health care services, while public health is focused

3 Immunization Dashboard: Fiji (database). World Health Organization, Geneva, Switzerland (accessed November 13, 2023), https://immunizationdata.who.int/pages/profiles/fji.html.

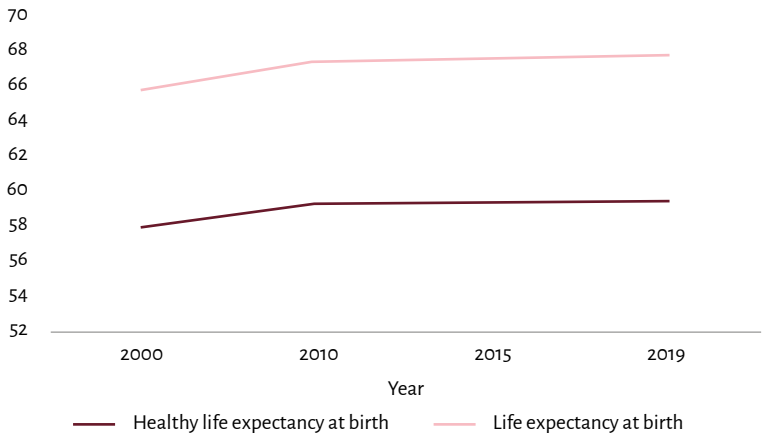
4 Country Profiles: Fiji (database). United Nations Children's Fund, New York (accessed November 13, 2023), https://data.unicef.org/country/fji/.

on promoting and protecting the health of entire populations. PHC use declined in the late 1980s, with drops in utilization at primary health centres. Explanations for this are mixed, with suggested causes being that general feelings at the time were that the goals of PHC had been "accomplished," the end of development partner funding, lack of an explicit government-driven PHC policy and budget, domestic instability, cultural changes in Fijian villages, and the redirection of global actors' attention to selective PHC interventions. Before 1999, the health care system was centralized, with a central office with four corporate divisions (primary and preventative services, health planning, hospital services, finance) making decisions, developing policy, monitoring, evaluating, and ensuring legislative and regulatory compliance (Mohammed, North, and Ashton 2016). Between 1999 and 2003, there were efforts to bring a more decentralized approach to the management of the health system. This aimed to bring services closer to the community to improve quality, increase access and equity, empower local agencies, increase innovation and efficiency, and bring health care and decision making closer to where people lived and worked (Mohammed, North, and Ashton 2016). In 2008, these changes were rolled back, and the system was recentralized (Roberts et al. 2011). In the last decade, health reforms in Fiji and the broader Pacific have aimed to bring the 'Healthy Islands' concept to the heart of its approach to health. The 'Healthy Islands' concept was envisioned in 1995 at the first Pacific Health Ministers Meetings, and reforms associated with it have been designed to encourage communities to take an active role in understanding the links between communities' individual behavior the living environment, the health system, and poor health outcomes. Although the definition of and approach to primary health care has been dynamic since independence, Fiji has historically prioritized PHC in health financing and has increased the volume of funds over the years, reflecting dedication to delivery of health services.[5]

5 Health Data Overview for the Republic of Fiji (database), World Health Organization, Geneva, Switzerland (accessed November 13, 2023),

These investments have partially contributed to small increases in life expectancy over the past two decades, but the gap between life expectancy and healthy life expectancy has increased as new and persistent challenges threaten gains. Life expectancy at birth increased from 65.5 years in 1990 to 68 years in 2019.[6] The gap between life expectancy and healthy life expectancy, or the years when people are living longer but in poor health, increased from 7.8 years in 2000 to 8.4 years in 2019 (Figure 2). The widening gap between life expectancy and healthy life expectancy has important implications for individual well-being and Fiji's health system utilization and development. PHC can play a crucial role in decreasing this gap by providing accessible, affordable preventative and curative health services while navigating these new and persistent challenges.

Figure 2. Life Expectancy and Healthy Life Expectancy in Fiji from 2000–19



Source: WHO 2023.

6 Country Profiles: Fiji (database), United Nations Children's Fund, New York (accessed November 13, 2023), https://data.unicef.org/country/fji/.

Changing demographics, lifestyles, and consumption patterns; increasing population size; and urbanization are contributing to large increases in noncommunicable diseases (NCDs). Like other Pacific Island countries, Fiji is undergoing a demographic transition, with people living longer and increasingly in urban areas. Fifty-six percent of the population lives in urban areas, with 20 percent of the urban population living in informal settlements[7] and a significant portion of the population living in poverty or below standards of living. Although the World Development Indicators show that 1 percent of the population lives on less than US$2.15 per day, other measures of poverty tell a different story; 24.1 percent of Fijians live below the national cost-of-basic-needs poverty line and 52.6 percent below the standard of living for upper-middle-income countries (US$6.85 per day) (World Bank Group, 2023). Lifestyle changes have contributed to the growing burden of NCDs, with the top risk factors driving death and disability due to metabolic and behavioral risks (Table 1). The top four risk factors increased significantly from 2009 to 2019, with the number of disability-adjusted life years (DALYS) per 100k population for high fasting plasma glucose increasing by 1,090.2, for body mass index by 881.0, for dietary risks by 445.4 and for tobacco by 202.0 from 2009 to 2019 (Table 2).[8] NCDs are now the primary cause of disease in Fiji, accounting for more than two-thirds of the disease burden, with the four major types of NCDs in Fiji being cardiovascular disease, diabetes mellitus, chronic respiratory disease, and cancer (WHO 2018a). Globally, Pacific Island countries have the highest rates of mortality due to NCDs among persons aged 30 and 70, and Fiji has one of the highest burdens of NCDs in the world, accounting for more than 80 percent of all deaths (Chand, Singh, and Kumar 2020).

7 Urbanization in Fiji: Building Inclusive & Sustainable Cities (database), UN Habitat, Nairobi, Kenya (accessed November 13, 2023), https://unhabitat.org/fiji.

8 Health by Location: Fiji (database), Institute for Health Metrics and Evaluation, University of Washington, Seattle, WA (accessed November 13, 2023), https://www.healthdata.org/research-analysis/health-by-location/profiles/fiji.

Table 1. Top 10 Causes of Deaths per 100k in 2019 and Rate Change 2009–2019, All Ages Combined

Cause	2009 rank	2019 rank	Change in deaths per 100k, 2009-19
Diabetes[a]	1	1	+28.5
Ischemic heart disease[a]	2	2	+22.0
Stroke[a]	3	3	+11.1
Chronic kidney disease[a]	4	4	+4.5
Asthma[a]	5	5	+1.0
Lower respiratory infection[b]	6	6	-0.8
Hypertensive heart disease[a]	8	7	+2.6
Neonatal disorders[b]	7	8	-4.8
Chronic obstructive pulmonary disease[a]	9	9	+2.2
Breast cancer[a]	10	10	+2.9

Source: Institute for Health Metrics and Evaluation 2019.
a. Noncommunicable diseases.
b. Communicable, maternal, neonatal, and nutritional diseases.

Table 2. Top 10 Risks Contributing to Disability-Adjusted Life Years (DALYs) per 100k in 2019 and Rate Change 2009–19, all ages combined

Risk	2009 rank	2019 rank	Change in DALYs per100k, 2009-19
High fasting plasma glucose[a]	1	1	+1,090.2
High body-mass index[a]	2	2	+881.0
High blood pressure[a]	3	3	+680.5
Dietary risks[b]	4	4	+445.5
Tobacco[b]	5	5	+202.0
High low-density lipoprotein (LDL) cholesterol[a]	7	6	+157.6
Malnutrition[b]	6	7	-636.3
Air pollution[c]	8	8	-393.0
Kidney dysfunction[a]	9	9	+220.7
Low physical activity[b]	10	10	+113.8

Source: Institute for Health Metrics and Evaluation 2019.
a. Metabolic risks.
b. Behavioral risks.
c. Environmental/occupational risks.

Persistent challenges remain, including those related to infectious diseases, maternal and child health, and nutrition, as well as provision of services across remote and disparate geographies. Over the past two decades there have been major infectious disease outbreaks, including measles, dengue fever, rubella, typhoid, leptospirosis, influenza, and diarrhea.[9] Neglected tropical diseases are still a contributor to preventable morbidity and mortality and often make people vulnerable to other infections and diseases. The country faces the dual challenge of providing health care to dispersed, often remote communities while addressing the pressure of a rapidly growing urban population. The rural and peri-urban population (44.1 percent of the population) is dispersed across nearly 332 islands (Fiji Bureau of Statistics 2018), presenting resourcing, logistical, and managerial challenges in delivery of care to remote areas.

The changing global context has important implications for health outcomes in Fiji, with climate change and other environmental challenges a particularly salient problem in the Pacific, along with the emergence of new health security threats that challenge progress. Like in many countries, the COVID-19 pandemic increased hospitalizations and deaths in Fiji and strained the health system as demand for services increased and investments were diverted to stop the pandemic.[10] Fiji faces a range of acute to long-term risks due to climate change, including extreme weather events such as floods, droughts, and cyclones; an increase in average temperatures; extended periods of drought; and rising sea levels (WHO and UNFCCC 2021). As a result, Fiji is experiencing coastal erosion, water shortages, salinization of water supplies, depleted fishery stocks, and an increase in vector-borne diseases, which have health implications ranging from changes in infectious disease transmission to difficulties delivering

9 Fiji Government (accessed November 13, 2023). https://fiji.gov.fj.

10 WHO Coronavirus Disease (COVID-19) Dashboard (database), World Health Organization, Geneva, Switzerland (accessed November 13, 2023), https://covid19.who.int.

health services because rising sea levels are likely to affect health centers positioned in hazardous areas impacted by rising sea levels.

Climate change may further increase the growing burden of NCDs, including obesity, diabetes, and heart disease. Rising temperatures and uncomfortable heat may lead to a reduction in activity and a more sedentary lifestyle, which can lead to a rise in obesity. It has been found that the number of hot days (hotter than 35°C) and extremely hot days has increased by 2 percent every 10 years since 1951 (McGree et al. 2019). By 2040, hot days will become twice as frequent, and by the end of the century, hot spells (periods characterized by several days of much warmer temperatures than local or regional averages) may account for up to 301 days per year.[11] Similarly, changing rainfall patterns, heat, and extreme weather that damage crops could increase food insecurity and push people to rely on more processed, canned, and preserved food as fresh produce becomes less available, also driving obesity, nutritional deficits, and NCD-related illnesses.

In the face of current challenges and stagnating life expectancy, the Fijian government has recognized the important role that PHC can play.

THE HEALTH SYSTEM

The predominantly publicly financed and managed health system is governed by the Ministry of Health and Medical Services (MHMS). In addition, the private sector is playing an increasingly important role through formal, for-profit providers (concentrated in urban areas), such as the Ba / Lautoka health care public-private partnership; adoption of the General Practitioners (GPs) scheme that the Fijian Government developed during the COVID-19 pandemic; and service provision by nongovernmental

11 Climate Change Knowledge Portal. World Bank, Washington, DC (accessed November 24, 2023), https://climateknowledgeportal.worldbank.org/.

organizations (NGOs). As defined for this assessment, the PHC system in Fiji is defined as the comprehensive range of services offered to address the majority of people's health needs through a variety of service delivery first-point-of-contact care using a person-centered approach. PHC services include health promotion, environmental health and health education, preventive care such as immunization and health screening, general outpatient diagnostic and curative care covering a comprehensive, rainbow set of services ("womb to tomb") approach in wellness; proactive care management through activities such as family planning and targeted populations with preventive services, rehabilitative and palliative care, and public health programs. PHC services are delivered through a number of channels, both public and private modalities and include outpatient services delivered through nursing stations and health centers, hospitals, community-led activities and engagement, proactive outreach, and program-specific activities. For-profit PHC facilities were not included in this assessment.

The health care system in Fiji is organized in four tiers: national, divisional, subdivisional, and medical area. At the national level, the MHMS is organized by department and unit, each responsible for specific aspects of health care, public health, and medical services, and includes departments for Wellness, Family Health, Health Protection, Health Information, etc. Health care is delivered through four administrative divisions: Central, Eastern, Northern, and Western. At the divisional and subdivisional levels, health officers are responsible for implementing and coordinating health services and play a crucial role in delivering health care and public health initiatives to communities. Each division oversees several subdivisions and facilities including nursing stations, which provide basic care only; health centers, which provide comprehensive care; and subdivisional and divisional hospitals, which provide ambulatory and inpatient care across all service levels. It is important to note that subdivisional and divisional hospitals deliver primary health care services, such as through outpatient departments and family planning services. The

Vital Signs Profile (VSP) assessment was unable to distinguish between the levels of service delivery within these facilities and the assessment therefore categorized hospitals as secondary care, with the exception of the national referral hospitals (the Colonial War Memorial Hospital, Labasa Hospital, Lautoka Hospital), which were categorized as tertiary care.

WHY PHCPI?

Understanding the current state of primary health care is essential for directing improvement efforts. To enable high-quality Primary Health Care in Fiji, it is important to have data on and insight into what is working, what is not and how to drive improvement. More and better data about PHC can continuously drive health care improvement and increase investment. Having better data helps policy makers identify gaps, steer investments, track progress, and be accountable. Having better data provides health care providers with insights to help them improve the care they deliver. Having better data provides information to everyone to help them demand improvements and track progress. Health for all is an ambitious goal, and it starts with greater understanding of Primary Health Care.

The Primary Health Care Performance Initiative (PHCPI) was a global partnership dedicated to transforming PHC. It was established based on the premise that strong PHC systems are the cornerstone of sustainable development and are essential for achieving Universal Health Coverage (UHC) and that improving PHC begins with better measurement. PHCPI partners included the World Bank, Bill and Melinda Gates Foundation, World Health Organization, United Nations Children's Fund, Global Fund, Results for Development, and Ariadne Labs. The partnership was dedicated to transforming the global state of PHC by working closely with governments and development partners looking to strengthen PHC, helping them analyze data, and providing them with information and support to drive evidence-based improvements.

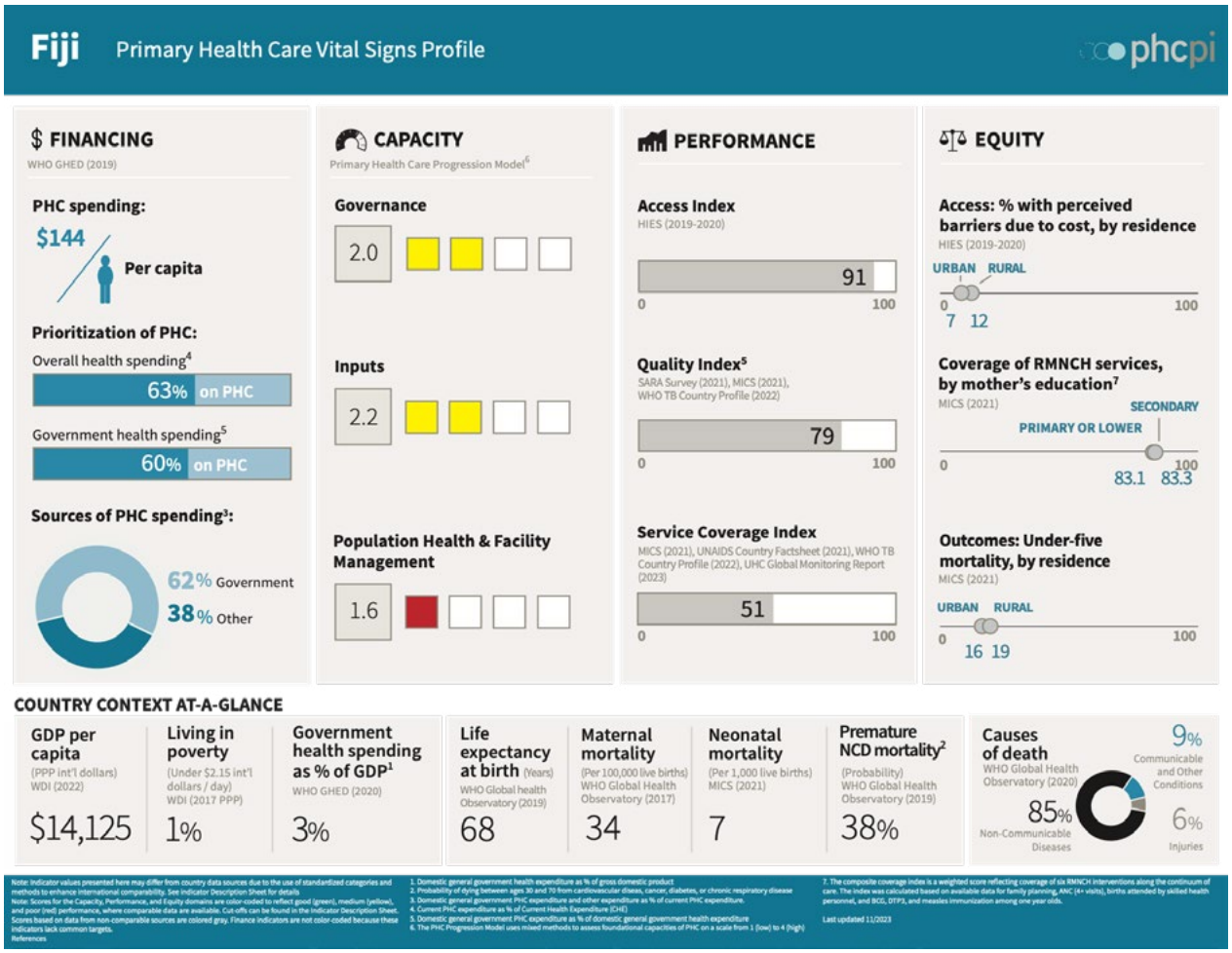
PHCPI developed technical tools to support countries in improving the performance of their primary health care systems. PHCPI's conceptual framework (Appendix A) was developed to describe the critical components of a strong PHC system (Veillard et al. 2017). The conceptual framework defined five core domains of a PHC system (coverage, access, equity, capacity, financing) and serves as the foundation of the initiative's activities. The framework is operationalized in the Vital Signs Profile (VSP), which provides a snapshot of PHC systems in individual countries, revealing where systems are strong and where they have challenges. It is designed to help countries and development partners identify priority areas for improvement and track improvements over time.

Four Pacific Island countries (Fiji, Kiribati, Solomon Islands, the Republic of the Marshall Islands) have, with the support of the World Bank, used PHCPI tools to take stock of current performance, safeguard what works well, and lay out a vision for areas requiring improvement. The VSP was created using the latest survey data and information gathered from an extensive document review and interviews with multiple health sector actors. As such, the VSP for Fiji currently includes information on the PHC system's capacity, performance, and equity and provides important insights into challenges in multiple levels in the system. In addition, and in support of goals of targeting NCDs and strengthening the gender-informed PHC approach, Fiji supplemented the standard PHCPI VSP with targeted deep dives into NCD and gender across conceptual domains. The gender deep dive was a detailed investigation into the capacity and performance of the PHC system to incorporate considerations around gender into planning and to deliver gender-sensitive services, including assessing how national-level policies address the specific needs of the different genders of the population and the accessibility of high-quality, gender-sensitive services at PHC facilities. The NCD deep dive assessed the capacity of the PHC system to detect, diagnose, treat, and manage NCDs. The assessment was designed to explore the policy and planning capacities required for effective NCD management. Questions for the gender- and

NCD-targeted deep dives were answered through a desk review and as part of key informant interviews. The gender deep dive included questions on whether national health policies and plans incorporate gender-responsive considerations of PHC; who is accountable for managing gender issues; how extensively disaggregated or gender-responsive data are used in decision making; whether quality assurance mechanisms promote gender sensitivity in service delivery; how vulnerable populations, especially women and girls, provide feedback to PHC facilities; and how PHC facilities ensure a nondiscriminatory environment (Box 3, 5, and 6). The NCD deep dive included questions on whether the national strategic health plan includes components on and risk factors for NCD; whether there are clear roles and responsibilities within PHC related to NCDs; data and evidence are used to develop best practices for management of key risk factors; policies include specific funding mechanisms for NCDs in PHC; and policies and strategies include a monitoring and evaluation (M&E) framework for NCDs (Box 1, 2, and 4).

The VSP (Figure 3) illustrates the strengths and weaknesses of Fiji's PHC system and provides the foundation for actionable policy recommendations for improvement. The results are presented using the core dimensions of PHC as identified by the PHCPI VSP. Additional details on VSP domains and corresponding results for Fiji are presented in Appendixes B and C. The following results have been mapped to five PHC domains: coverage, access, equity, capacity, and financing. Each domain's performance is measured using a collection of best-practice indicators derived from selected qualitative and quantitative data sources. Presenting the findings in such a manner provides a comprehensive, nuanced analysis of Fiji's PHC system. Expansion of these results in terms of NCDs and from a gender lens are provided in boxes. Policy makers, donors, advocates, and citizens can use the results to better understand and ultimately improve PHC in Fiji.

Figure 3. Fiji Primary Health Care Vital Signs Profile



KEY FINDINGS FROM THE VSP ASSESSMENT

ACCESS

The access domain in the PHCPI framework encompasses individuals' perspectives on receiving care; specifically, it captures whether individuals can receive appropriate primary health care when they need it without facing undue financial and geographic barriers. Access to care is an important PHC dimension, because care must be accessible to be considered high performing. Reducing supply-side and perceived barriers to care is an important priority for policy makers seeking to improve PHC performance. The two standard VSP indicators for access are perceived barriers due to treatment costs and perceived barriers due to distance, typically measured through household surveys such as the Demographic and Health Survey (DHS). Deprivation data from the 2019-2020 Household Income and Expenditure Survey (HIES) Report by the Fiji Bureau of Statistics allows for measurement of a proxy indicator for financial barriers to access. The HIES indicates that nearly one in ten people in Fiji (9 percent) cannot afford to buy all the medicines that their doctors prescribe. Deprivation varies according to residence, with 12 percent of people in rural areas deprived of all prescribed medicines, compared with 7 percent in urban areas (Fiji Bureau of Statistics 2021). The financial burden associated with health expenditure also varies by disease, with the WHO reporting that 40 percent of people with tuberculosis and their households face catastrophic costs. This suggests that significant progress is needed to reach the WHO's End TB Strategy target that no TB patients and their households will incur catastrophic expenditures due to the disease (WHO 2017a). No up-to-date information on barriers to care in Fiji due to distance is available, highlighting the need to better understand other dimensions of access, particularly for vulnerable populations.

SERVICE COVERAGE

The PHCPI assessment captures the coverage of RMNCH, infectious diseases, and NCDs. The indicators selected to capture the effective coverage across these areas are presented in Table 3. The VSP indicators were chosen through extensive literature reviews and consultations with international experts (Veillard et al. 2017). Service coverage data were collected from the 2017 and 2023 Universal Health Coverage Global Monitoring Reports, Multiple Indicator Cluster Survey (MICS) 2021, WHO Tuberculosis Country Profile 2023, and WHO Global Tuberculosis Report 2017.

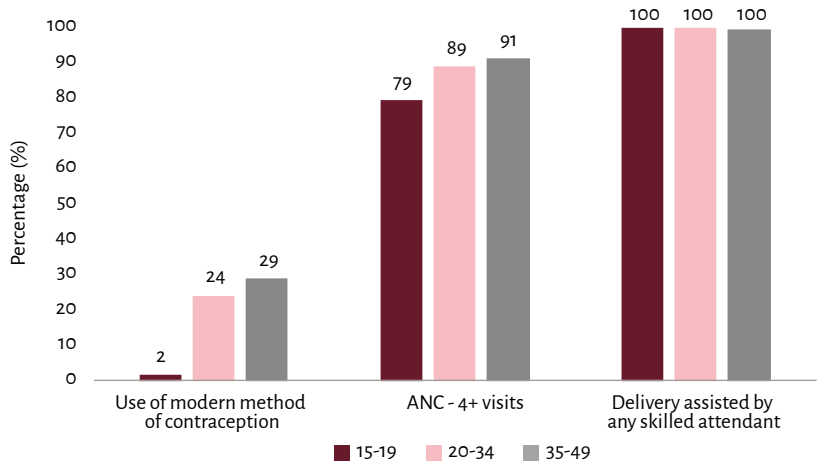
Table 3. Service Coverage of RMNCH, infectious disease, and NCDs

Indicator	Percentage (2015)	Percentage (2021)	Percentage point change	Source
Reproductive, maternal, newborn, and child health				
Demand for family planning satisfied with modern methods	67%[c]	51%	↓16	MICS 2021, UHC Global Monitoring Report 2017 (2015 data)
Antenatal care coverage (4+ visits)	94%[c]	89%	↓5	MICS 2021, UHC Global Monitoring Report 2017 (2015 data)
Coverage of DTP3 vaccination	99%[c]	95%	↓4	MICS 2021, UHC Global Monitoring Report 2017 (2015 data)
Care-seeking for suspected child pneumonia[b]	72%[c]	68%	↓4	UHC Global Monitoring Report (WHO and World Bank 2017, 2023) (2021 data)
Infectious disease				
Children aged < 5 years with diarrhea receiving oral rehydration salts	—	54%	—	MICS 2021
People living with Human Immunodeficiency Viruses (HIV) receiving anti-retroviral treatment (ART)	31%	45%	↑14	UHC Global Monitoring Report (WHO and World Bank 2017, 2023) (2021 data)
TB cases detected and treated with success	52%	30%	↓22	WHO TB Country Profile 2023 (2021 cases 2020 cohort), WHO Global Tuberculosis Report 2017 (2016 cases 2015 cohort)
Noncommunicable diseases				
Prevalence of treatment among adults with hypertension[c]	—	35%		UHC Global Monitoring Report (WHO and World Bank 2017, 2023)

Note: MICS = Multiple Indicator Cluster Survey; — = not available.
a. These 2015 comparison data are from the 2017 Universal Health Coverage Global Monitoring Report and may not be directly comparable with the methods used to ascertain these indicators in the MICS 2021.
b. Percentage of children under 5 years of age with symptoms of acute respiratory infection for whom advice or treatment was sought.
c. The indicator reflects a modeled estimate for prevalence of treatment (taking medicine) for hypertension in adults aged 30 to 79 with hypertension, based on age-standardized estimates. For more details see Tracking UHC: 2023 Global Monitoring Report.

The VSP assessment in Fiji indicates a decline in RMNCH service coverage since 2015. Antenatal care (ANC) coverage (four-plus visits) decreased from 94 percent in 2015 to 89 percent in 2021, while the demand for family planning satisfied by modern methods dropped by sixteen percentage points, from 67 percent to 51 percent. The percentage of pregnant girls and women attending four or more ANC visits varies according to maternal age. Teenage mothers are more vulnerable and receive less care, with only 79 percent of adolescents ages 15 to 19 having four or more visits, compared with 91 percent of adult mothers ages 35 to 49. Similar disparities are also seen in the use of modern contraception, with 2 percent of women currently married or in union and sexually active unmarried women ages 15 to 19 using modern methods of contraception, compared with 29 percent of women ages 35 to 49 (Figure 4). All deliveries were assisted by a skilled attendant (100 percent) across all age categories (Figure 4). Coverage of diphtheria-tetanus-pertussis, third dose (DTP3) vaccination declined slightly from 99 percent in 2015 to 95 percent in 2021. Care seeking for suspected child pneumonia, defined as the percentage of children under five with fever in the last two weeks for whom advice or treatment was sought, declined from 72 percent in 2015 to 68 percent in 2021; 65 percent sought care from a government health center, 26 percent from a government hospital, and only 4 percent from a private hospital or clinic, highlighting reliance on publicly provided health care for child health (Figure 5).

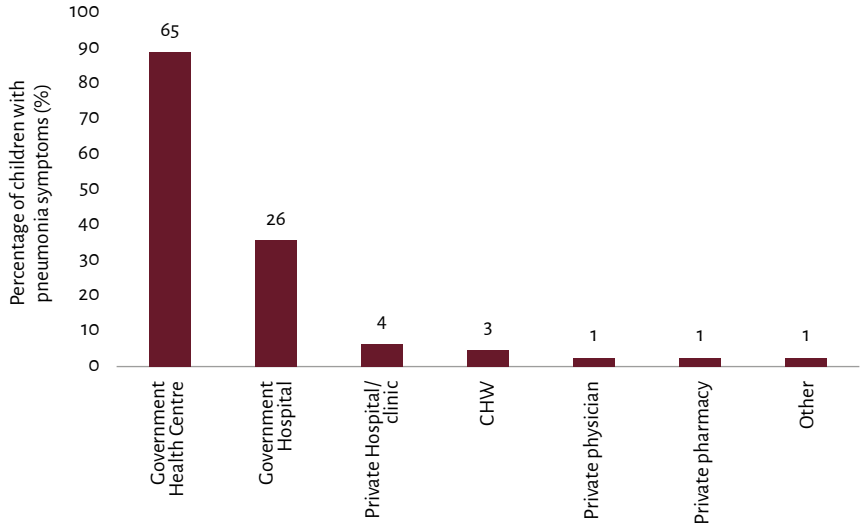
Figure 4. Selected Reproductive and Maternal Health Indicators by Age Category



Source: MICS 2021

Note: Use of modern method of contraception was calculated as percentage of all women, currently married or in union, and sexually active unmarried adolescent girls ages 15-19 who are using (or whose partner is using) any modern contraceptive method

Figure 5. Facility Type Where Care Is Sought for Childhood Pneumonia Symptoms



Source: MICS 2021

There is room for improvement in coverage of infectious disease services related to treatment of childhood diarrhea with oral rehydration salts, people with HIV receiving antiretroviral therapy (ART), and TB cases detected and treated with success. According to the 2023 UHC Global Monitoring Report, 45 percent of people with HIV are receiving treatment. Although this is an increase from 31 percent ART coverage in 2015, a significant gap remains in the percentage of HIV-positive individuals who are not receiving treatment. Fiji also faces challenges in detecting and treating tuberculosis, with the percentage of cases detected and treated declining from 52 percent in 2015 to 30 percent in 2023. Examining this indicator according to its component parts, tuberculosis case notification, defined as the total cases notified over the estimated tuberculosis incidence, declined from 60 percent in 2016 to 56 percent in 2021. Treatment success, defined as the percentage of known people with tuberculosis who were successfully treated, decreased significantly from 86 percent in 2016 to 54 percent in 2021, emphasizing the need for improved TB detection and treatment.

Coverage of NCD services, including treatment of adults with hypertension, requires attention as the prevalence of NCDs increases in the country. According to the 2023 UHC Global Monitoring Report, the prevalence of treatment in adults with hypertension is 35 percent. The indicator reflects the modeled estimate for prevalence of treatment (taking medicine) for hypertension in adults ages 30 to 79 with hypertension based on age-standardized estimates.

QUALITY

In the PHCPI framework, PHC quality encompasses not only clinical quality, but also the core principles of service provision that have been shown to impact primary health care quality. These include comprehensiveness, continuity, and person centeredness of service

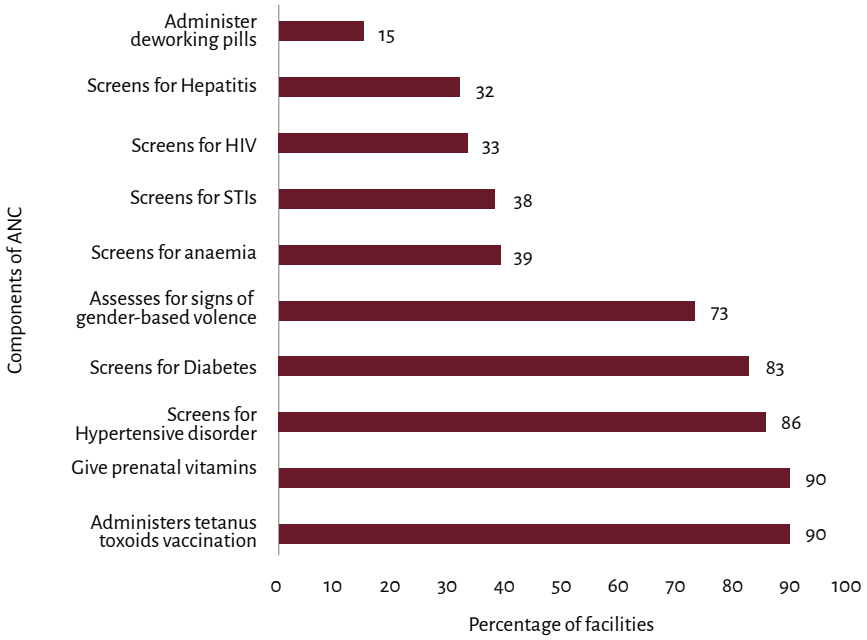
delivery, as well as aspects of provider competence and safety. Data on quality measures are from the 2021 Service Availability and Readiness Assessment (SARA) and the 2021 MICS. The 2021 SARA assessed service delivery across all levels of care provided in the country, with an emphasis on evaluating facility infrastructure, equipment, and supplies.

The comprehensiveness indicators of the VSP suggest that facilities are unable to offer the services required to meet the growing demand for and ensure coverage of PHC services. Comprehensiveness in health care covers the provision of holistic and suitable care across a broad spectrum of health needs, and the SARA survey reveals noticeable gaps in the comprehensiveness of services for maternal and child health, NCDs, and infectious diseases. The VSP methodology uses three indicators to measure comprehensiveness of PHC service delivery: the proportion of facilities offering diagnosis and treatment for three NCD services, three primary infectious disease services, and five maternal and child health services.

Even when services are available, many facilities do not have the capacity to provide all components of high-quality antenatal care. This is particularly evident in the provision of RMNCH, with 73 percent of facilities offering a range of services, including care for sick children, vaccination, family planning, antenatal care, and guidelines for prevention of mother-to-child transmission of HIV (PMTCT). Only 11 percent of facilities offer prevention of mother-to-child transmission services, similar to the finding from the 2020 Health Facility Readiness and Service Availability (HFRSA) assessment that 14 percent of facilities provided prevention of mother-to-child transmission services. A large proportion of facilities reported providing adult and adolescent contraception (93 percent) and oral rehydration salts for children with diarrhea (96 percent). Improvements could be made in the percentage of facilities providing vaccination on a weekly or more routine basis (86 percent) and ANC services (81 percent). Breaking down ANC by the components delivered during ANC visits reveals that facilities often lack the capacity to provide crucial elements of high-

quality ANC care. For example, less than 30 percent of facilities screen for anemia, sexually transmitted infections (STIs), HIV, or hepatitis and administer deworming pills (Figure 6).

Figure 6. Percentage of Facilities Reporting Provision of Key Components of ANC



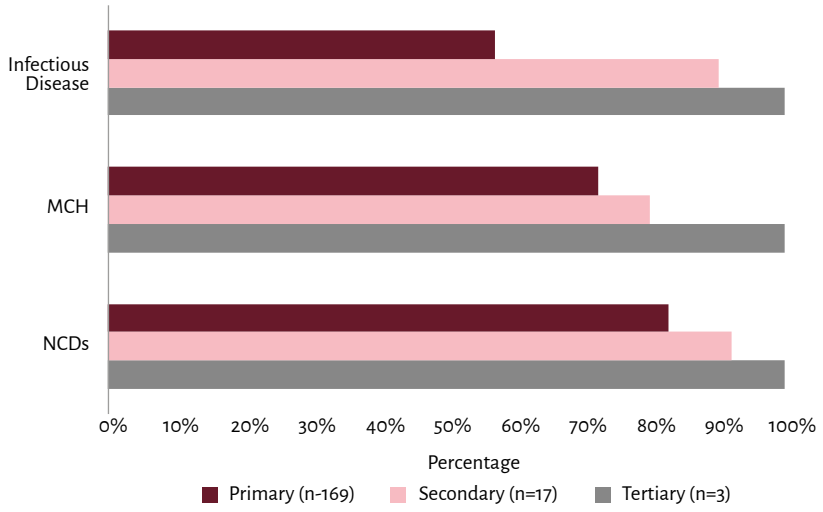
Source: HFRSA 2020

The lack of infectious disease services in Fiji, coupled with the ongoing burden of NCDs, emphasizes the pressing need for improvement. According to the 2021 SARA health survey data, 84 percent of facilities offering PHC provided diagnosis and treatment for three NCDs: diabetes (84 percent), chronic respiratory disease (83 percent), and cardiovascular disease (85 percent). A smaller percentage of facilities (61 percent) had services available for three infectious diseases: STI testing (74 percent); tuberculosis diagnosis and treatment (71 percent); and HIV testing, counseling, and treatment (38 percent). Fiji's National Strategic Action Plan (NSAP) 2016-2020 on STIs, HIV, and AIDS focused on reducing new infections of HIV and STIs, while government policy mandates HIV testing during ANC visits. However, low comprehensiveness across all condition types indicates room for improvement in availability of infectious disease

services. This is particularly important when considering the simultaneous low coverage of infectious disease services and the ongoing burden of NCDs.

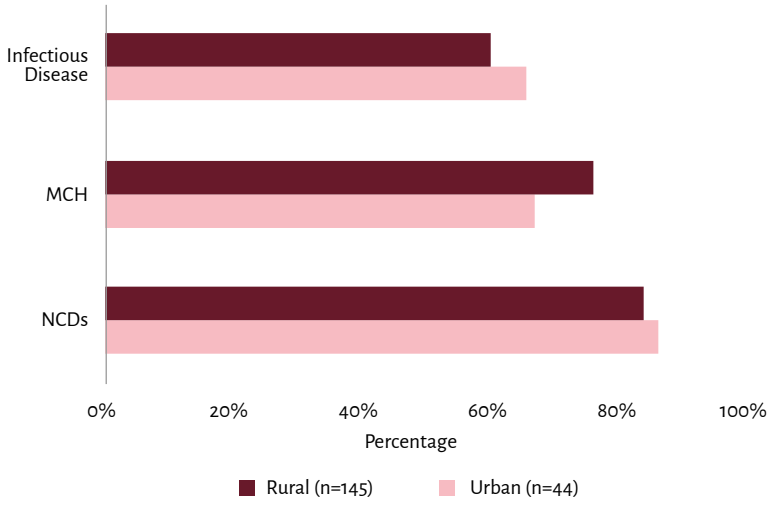
Examining the provision of services according to level of the health system demonstrates strong provision of care at the tertiary level, with 100 percent of facilities providing infectious disease, maternal and child health care, and NCD services but progress is needed at the PHC level to provide a comprehensive set of services. Care at the secondary level is strong for infectious disease (90 percent) and NCDs (92 percent), with room for improvement for maternal and child health care (80 percent). Care is less comprehensive at the primary level, with 57 percent of facilities providing infectious disease services, 72 percent providing maternal and child health care MCH services, and 83 percent providing NCD services (Figure 7). There are disparities in care provision according to location, with a higher percentage of urban facilities providing NCD (86 percent) and infectious disease care (65 percent), and rural facilities providing a higher percentage of MCH care (76 percent) (Figure 8).

Figure 7. Percentage of Facilities Offering Services by Condition Type and Health System Level



Source: SARA 2021

Figure 8. Percentage of Facilities Offering Services by Condition Type and Urban/Rural Setting



Source: SARA 2021

Continuity of care is high for DTP vaccination, but improvement is needed for continuity of tuberculosis treatment. Care continuity assesses the extent to which patients experience a series of discrete health care events as coherent and consistent with their medical needs and personal context. In the context of the VSP, two key indicators are used to gauge care continuity: the percentage of successfully treated cases of tuberculosis and the DTP3 dropout rate. According to the WHO Global Tuberculosis Report (2022), 54 percent of diagnosed TB patients underwent successful treatment in 2020—a significant decrease from 86 percent in 2016. Information on DTP3 continuity is promising, with 96 percent of children receiving a third dose of DTP after their initial dose.

The 2021 SARA survey indicates moderate adherence to patient safety practices. PHCPI uses two measures to determine patient safety at health facilities: adequate infection prevention and control, and adequate waste disposal. Adequate infection prevention and control refers to the proportion of rooms (family planning, sick child, antenatal care, and NCD) where all infection control tracer items are present. The items include soap and running water or hand disinfectant, storage for sharps waste, gloves,

and surface disinfectant, appropriate storage of infectious waste, and availability of auto-disable syringes. In 2021, 92 percent of facilities offering PHC had adequate infection control. Adequate waste disposal refers to the adherence to standards for disposing of medical and hazardous waste, sharps, and the availability of guidelines for waste disposal at the facility. In 2021, 82 percent of facilities had adequate waste disposal practices. Waste collection is ultimately disposed of along with general, household, and industrial waste without treatment because Fiji has not had a functioning medical waste incinerator since 2019.

Information is limited on three components of quality care (provider competence, person centeredness, and provider availability), highlighting the need to routinely collect and use data on important components of effective health care delivery. The VSP methodology uses two indicators to gauge provider availability: the proportion of consultations exceeding 10 minutes in duration, and the proportion of clinical staff absences compared to the expected staffing levels. The VSP assesses person centeredness in the PHC system by estimating the proportion of caregivers who indicate that health care providers informed them of their sick child's diagnosis or indicated the name of the child's disease or condition. Person centeredness measures performance from the patient's perspective, assessing whether patients are engaged and viewed as equal partners in their care experience. Improving the measurement of person centeredness is important for understanding how empowered users of the health system are and can help guide strategies to improve patient satisfaction. Focusing on measurement of person centeredness can improve health and clinical outcomes by identifying target strategies or populations and increasing the efficiency and cost-effectiveness of services. Provider competence, which refers to providers' possession of the necessary knowledge, skills, abilities, and traits to deliver high-quality services successfully and effectively, is assessed using three key indicators (ANC quality score, sick child services quality score, and diagnostic accuracy) that measure provider adherence to the clinical guidelines during PHC consultations.

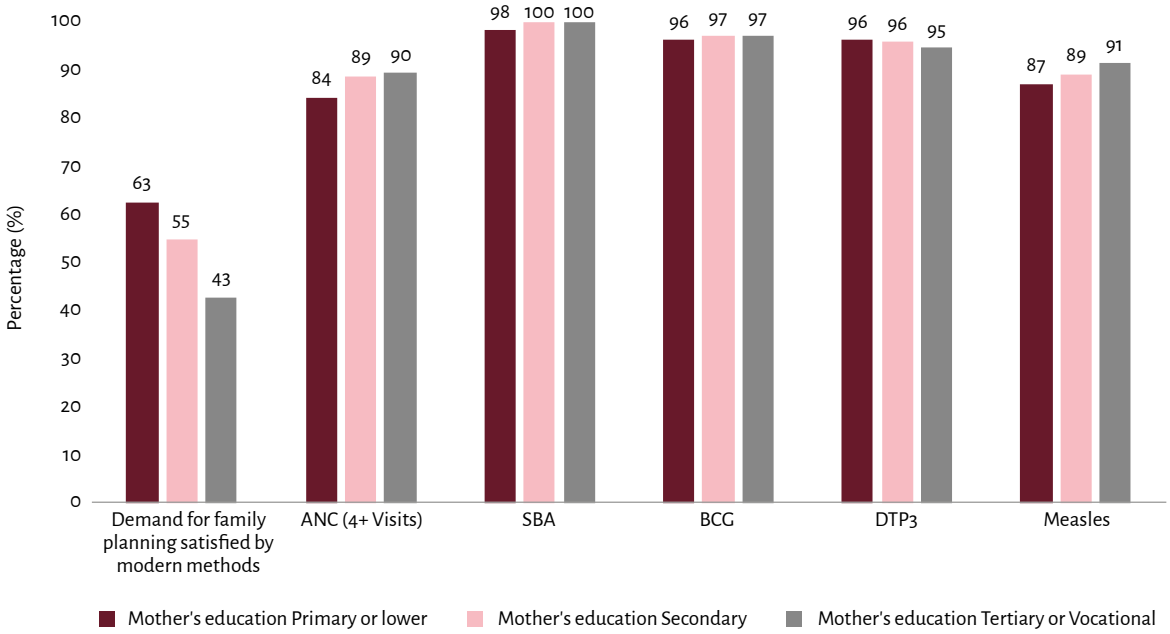
EQUITY

Equitable primary health care coverage and access reduce disparities in health outcomes between populations. The VSP measures equity across access, coverage, and outcomes according to socioeconomic status, mother's education, and place of residence. Equity is assessed through the difference in perceived financial barriers to health care according to wealth quintile, the differences in effective maternal and child health care services based on a mother's level of education, and differences in urban and rural children's mortality rates. Differences in perceived financial barriers are calculated using a proxy indicator from the 2019-2020 HIES, and differences in effective maternal and child health care services based on mother's level of education and differences in urban and rural children's mortality rates are calculated using data from MICS 2021.

Data from the 2019-2020 HIES show slight disparities according to urban and rural residence in financial deprivation related to medications. The HIES indicates that 12 percent of people in rural areas and 7 percent in urban areas unable to afford all the medicines that their doctors prescribe (Fiji Bureau of Statistics 2021).

There is some variation in the coverage of RMNCH services according to mother's education. Demand for family planning, defined as the proportion of women who are currently using contraception over the total demand for contraception, is higher among mothers with only primary or lower education (63 percent) than those with tertiary or vocational education (43 percent). There are also disparities are also seen across the percentage of mothers receiving four or more ANC visits, with 84 percent of mothers with primary or lower education and 90 percent of mothers with tertiary or vocational education attending four or more visits. Similar coverage levels are seen across education levels for skilled birth attendance (SBA) and Bacillus Calmette–Guérin (BCG), DTP3, and measles vaccinations (Figure 9).

Figure 9. Reproductive, Maternal, Newborn, and Child Health Service Coverage by Mother's Educational Level



Source: MICS 2021.

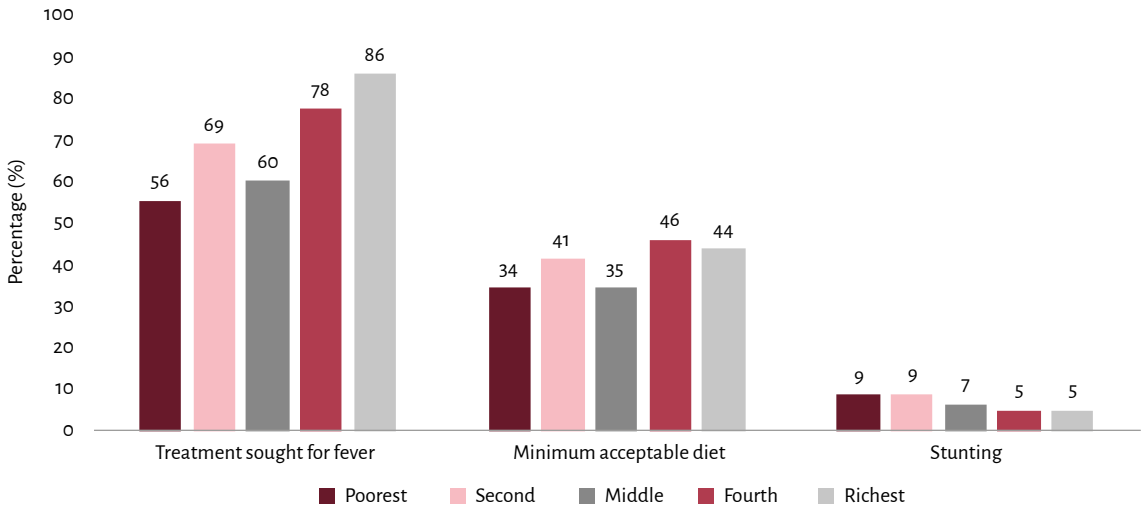
Note: Demand for family planning is calculated among women, currently married or in union, and sexually active unmarried adolescent girls aged 15-19 using modern methods of contraception. SBA indicates delivery assisted by any skilled attendant. BCG indicates the percentage of children aged 12-23 months who received BCG vaccination. DTP3 indicates the percentage of children aged 12-23 months who received DTP-HepB-Hib 3 vaccination. Measles indicates the percentage of children aged 12-23 months who received Measles-Rubella 1 vaccination.

Source: MICS 2021

Examining selected infectious disease and nutrition coverage indicators shows substantial variation across division and wealth quintile (Figure 10). There are disparities in the proportion of children under five with fever for whom advice or treatment was sought according to division (65 percent in Central to 72 percent in Western) and wealth quintile (56 percent in the poorest to 86 percent in the richest). Considering factors beyond seeking health services that influence child health, inequalities in nutrition outcomes are evident; 12 percent of children in the Northern division are stunted compared to 6 percent in the Western division, while 9 percent of children in the poorest wealth quintile were stunted compared to 5 percent in the richest quintile. There are also disparities in the percentage of children

receiving a minimum acceptable diet according to division and wealth quintile. Minimum acceptable diet is defined as children 6-23 months who received minimum dietary diversity and meal frequency for non-breastfed children, and two milk feedings or more and minimum dietary diversity for breastfed children; 48 percent of children in the Central division achieve a minimum acceptable diet, while only 22 percent in the Northern division do. By wealth quintile, 34 percent of children in the poorest quintile achieve a minimum acceptable diet compared to 44 percent in the richest wealth quintile.

Figure 10. Selected Infectious Disease and Nutrition Coverage Indicators by Wealth Quintile

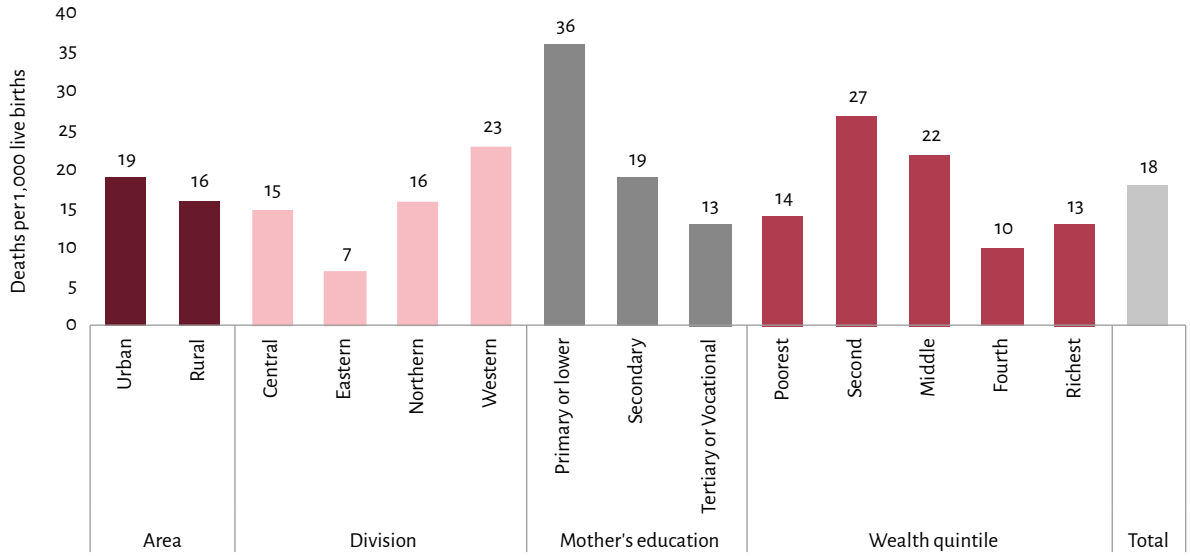


Source: MICS 2021.
Note: Treatment sought for fever is defined as the percentage of children aged 0-59 months with fever in the last two weeks for whom advice or treatment was sought. To have a minimum acceptable diet, a child must have received: (1) the appropriate number of meals/snacks/meal feeds; (2) food items from at least 5 out of 8 food groups for breastfed children, and 4 out of 7 food groups for non-breastfed children, and (3) at least two milk feeds for non-breastfed children.

Ultimately, inequities in primary care access and coverage are linked to key population health outcomes and result in excess mortality. Data from MICS 2021 show slight differences in under-five mortality rates for urban (19 deaths per 1,000 live births) versus rural (16 deaths per 1,000 live births) residence. Rural under-five mortality is reported as 16 per 1,000 live births while urban under-five mortality is reported as 19 deaths per 1,000 live births. There was also substantial variation in the under-five mortality

rate according to divisions, with a high of 23 deaths per 1,000 live births in Western division and a low of 7 in Eastern division. Rates also varied significantly according to mother's education, with a high of 36 deaths per 1,000 live births among mothers with primary or lower education compared to 13 deaths per 1,000 live births among mothers with tertiary or vocational education (Figure 11).

Figure 11. Under-Five Mortality Rate by Area, Division, Mother's Education, and Wealth Quintile



Source: MICS 2021

CAPACITY

PHC capacity refers to the ability of a system to deliver high-quality PHC services. In the PHCPI framework, capacity comprises three subdomains: governance, inputs, and population health and facility management. Governance includes an assessment of PHC policies, quality management infrastructure, and social accountability, as well as the ability of the system to appropriately adjust to population health needs. Inputs reflect availability, equitable distribution, and quality of essential service delivery inputs, including medicines, supplies, workforce, facility infrastructure,

information systems, and funds at the facility level. Population health and facility management involves active outreach and engagement with the community and planning and decision making at the local level. The capacity domain of the VSP also examines facility organization and management, including effective organization of facility operations; deployment of human resources in multidisciplinary teams; routine collection and use of information systems to establish targets and monitor progress on quality improvement initiatives; and ability of facility managers to oversee and support these processes.

GOVERNANCE

Effective PHC system governance and leadership is the starting point for a strong, resilient PHC system. Strong PHC governance has many downstream effects, including efficient resource allocation, improved local governance and facility management for population trust and efficient resource allocation, higher-quality service delivery, and improved population health outcomes. The governance sub-domain includes an assessment of PHC policies, quality management infrastructure, and social accountability and the ability of the system to appropriately adjust to population health needs. Improving governance is typically a priority for policy makers seeking to increase PHC capacity and improve downstream performance.

There is no explicit or shared definition of PHC across health policies in Fiji. Health policies capture the government's commitment to health and prioritization of PHC in theory and practice and enable many other aspects of PHC capacity and performance. The National Strategic Plan 2020-2025, which outlines strategic priorities and sets the direction for the MHMS for 2020 to 2025, does not clearly define PHC, but its principles are integrated into the broader aims and service delivery priorities. This means that the National Strategic Plan 2020-2025 emphasizes the key functions of PHC—first point of contact, continuity, comprehensiveness, coordination, person-

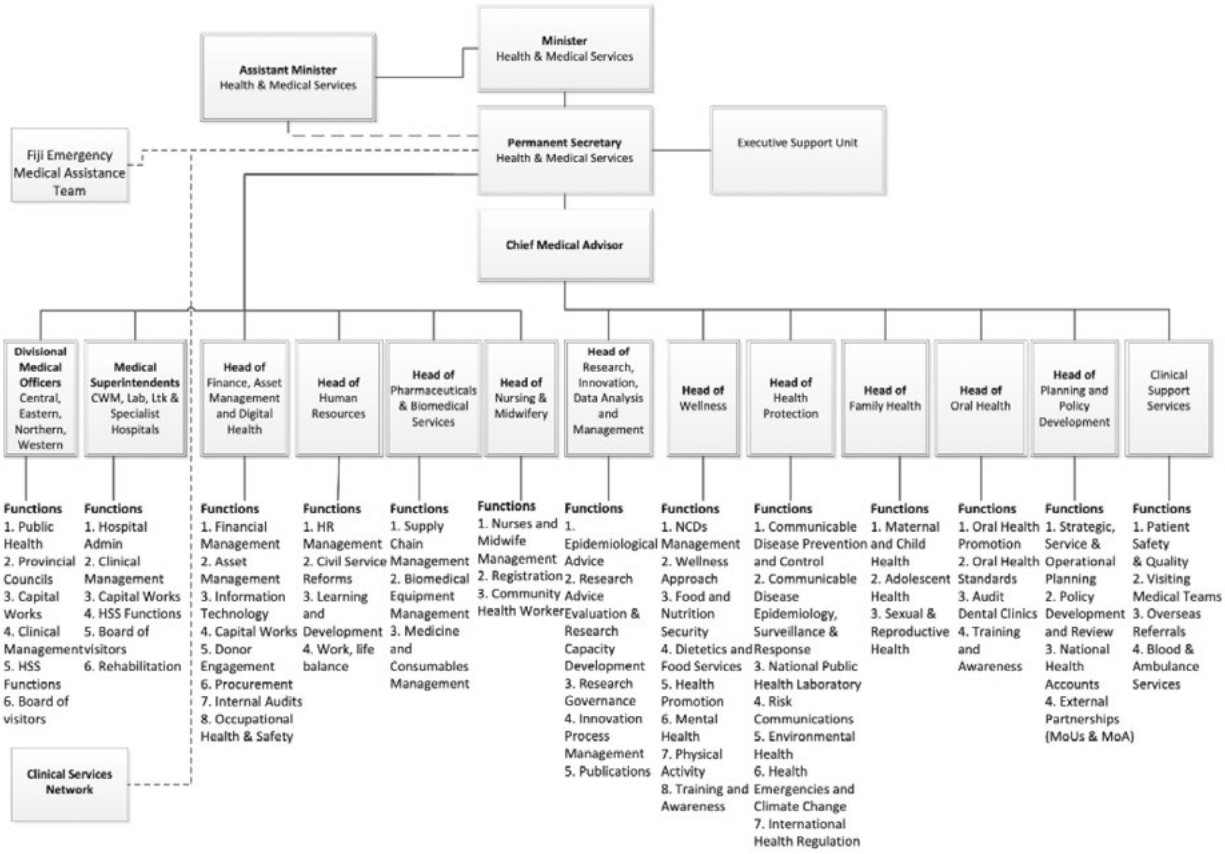
centered care—and integrates PHC into other service delivery structures. The National Strategic Plan 2020-2025 includes some, but not all, of the essential elements of strong PHC policies. It is formulated through a participatory process and embedded in a legal framework to enable its operationalization. Although the plan includes an M&E framework with key performance indicators, the service package for PHC is not clearly defined, and financing mechanisms are not identified.

Box 1. Overview of Noncommunicable Disease (NCD) Strategy and Policies in Fiji

There is a strong emphasis on NCDs in key strategic plans and policies in Fiji through the Ministry of Health and Medical Services (MHMS) Strategic Plan (2020-25) and National Wellness Policy. The MHMS Strategic Plan includes components designed to address NCDs, providing an in-depth explanation of the challenges and risk factors associated with high prevalence of NCDs. The MHMS also outlines a package of essential NCD services through the World Health Organization's package of essential NCD services framework, providing a critical tool for NCD diagnosis and management in primary health care. The strategic plan also emphasizes the importance of partnerships and collaboration, recognizing that a collective effort is essential to reducing the burden of NCDs, and highlights key outcomes related to NCDs, although it does not specify the exact indicators used for measuring the impact of implementing NCD interventions. The plan is linked to the National Wellness Policy, which outlines a comprehensive approach to addressing risk factors that contribute to the high burden of NCDs. The components of the National Wellness Policy also incorporate inter- and multisectoral approaches to addressing NCDs, specifying the roles of civil society organizations, nongovernmental organizations, government partners, statutory bodies, academia, and the community. Although the MHMS Strategic Plan and National Wellness Policy guide the NCD agenda, Fiji previously developed the Health Sector Plan for NCDs (2015-19), which provided a dedicated results framework outlining plans and budgets for addressing risk factors such as diet, physical activity, tobacco, alcohol, and public health services. To curb the growing, widespread burden of NCDs, health system and outcome targets must be clearly set and accountability for achieving targets upheld.

PHC is covered to varying degrees through programs whose remit covers PHC topics such as wellness, family health, and infectious disease. Challenges lie in the different interpretations of PHC in action and lack of coordination. Although PHC is well integrated at the facility and service delivery level—for example, a PHC facility may offer NCD diagnostic services, ANC care for pregnant women, immunizations, and conduct community outreach—it is not sufficiently captured and collated at the policy and leadership level. Additionally, a proliferation of vertical programs implemented from 2016 to 2021 complicates understanding of PHC at the national level. Authority for PHC is thus divided among divisions and programs that are responsible for their respective domains, spanning PHC and non-PHC (Figure 12). This contributes to fragmentation and confusion regarding the scope of PHC strategies, and there is no collated understanding of implementation and accountability. It is likely that this obscures the true scope of PHC-related activities being implemented and may contribute to duplication of effort and inefficiency. Although the national-level organizational structure spreads responsibility for PHC-related activities across vertical programs, the MHMS had implemented command structures at the subnational level during COVID-19 that could serve as a foundation for decentralizing and coordinating PHC leadership at the divisional and subdivisional levels.

Figure 12. Ministry of Health and Medical Services Organizational Structure



Source: MHMS Annual Operational Plan 2022-2023.

Box 2. Overview of Responsibilities and Roles of Implementing Noncommunicable Disease (NCD) Programs in Fiji

The Ministry of Health and Medical Services (MHMS) NCD and Wellness Department has full authority over implementation of NCD services and programs, although impact is yet to translate into improved outcomes, and there are challenges in documenting implementation and impact. The MHMS Strategic Plan includes a component on decentralizing clinical services, which dedicates subsections to NCDs. There is a component dedicated to enhancing clinical management by implementing the WHO package of essential NCD services (the PEN package), which specifies provision of a

range of clinical services dedicated to early detection and management of cardiovascular disease, diabetes, chronic respiratory disease, and cancer in PHC facilities. The PEN package is also adapted to Fiji's local guidelines and context and includes the cardiovascular risk assessment and management protocol (CRAMP), Oceania risk management charts, and the piloting of a community package of essential NCD services, which trains community health workers to monitor NCDs and refer patients. Furthermore, Fiji established a list of core NCD medicines within its essential medicines list in 2015 to treat several key NCDs, including cardiovascular disease, diabetes, mental and behavioral disorders, and respiratory illnesses, but the essential medicines list has not been updated and does not reflect recent changes to treatment guidelines, such as the Nephrology Clinical Guidelines developed in 2022. Despite these advances, there are several areas in which NCDs could be better addressed in PHC. Specifically, there is little to no formal documentation on implementation of the package of essential NCD services within facilities. While the Role Delineation work provides a broad overview of PHC providers roles and responsibilities, it does not integrate specific roles of health care providers in diagnosing, managing, treating, and referring patients with NCDs.

Considering the high and growing burden, early detection and intervention to address NCD risk factors in children and youth at scale is both urgent and essential for a healthier, more-productive Fijian working-age population.

There are activities and interventions that target quality of care, but their varying types, scope, leadership, and effectiveness reflect the fragmentation of PHC and limit the effectiveness of the overarching quality management infrastructure. These include systems for registering and licensing health care workers through the Medical Council, Nursing Council, Allied Health Practitioners Society, and clinical service networks that provide clinical advice for various disciplines; infection control guidelines and procedures; and some tertiary facility–focused work on collaborative, team-based learning and improvement forums such as morbidity and mortality reviews. Quality activities are implemented in siloes within the MHMS and non-ministry stakeholders, and they

often emphasize implementation of activities rather than outcomes and effectiveness. Strategies to institutionalize, monitor, and enforce quality of care at the PHC level are not comprehensively identified, although the articulation of Fiji's direction on quality embedded within the National Strategic Plan 2020-2025 and clearly stated leadership commitment to institutionalize quality of care throughout the health care system are important steps toward establishing purposeful quality management infrastructure for the planning, control activities, and improvement work that underpins delivery of good-quality health care services.

Although the MHMS has a long history of engaging with cross-sectoral and nongovernmental entities regarding health care, the ambiguity and fragmentation of PHC pose a challenge for social accountability. Strong social accountability leverages national-level collaboration and input to hold a country accountable to existing and emerging social concerns, priorities, and commitments. There is no clearly identified mechanism for cross-MHMS programmatic engagement on PHC outside of disaster response, which is organized under the Fiji Cluster System's health cluster. Various programs within the MHMS reach out to external stakeholders independently, leading to fragmented engagement. Cross-government coordination on PHC-related topics occurs in a similar fashion within the programs or the Cluster System, and the coordination mechanisms are not well defined. Despite engagement occurring on an ad hoc basis, there are numerous examples of cross-sector integrated planning between the MHMS and other ministries, including the Ministry of Education; Ministry of Women, Children, and Poverty Alleviation; Ministry of Youth and Sports; Ministry of Works, Transport, and Public Utilities; and Registrar of Births, Deaths, and Marriages. Private sector, civil society, and nongovernmental organization stakeholders are informed of relevant health care activities and given opportunity to provide feedback on implementation and results. Public disclosure on PHC implementation is rare, because of the lack of timely analysis, hindering adequate capture and dissemination of results. Regular statistics and reports are commonly not available online.

In addition to strategic policy frameworks, effective oversight, coalition building, and efforts to leverage system design and accountability, an important element of PHC governance is the ability to adjust to population health needs. This includes routine collection of information about population health status and needs, appropriate analysis and use of this information to set and implement priorities, and continual learning and adaptation based on emerging evidence and data.

Systems that support adjustment of PHC to changing population health needs are being established. In terms of surveillance, the system is functional but fragmented; systems include the Early Warning and Syndromic Systems (EWARS), Community-Based Surveillance (CBS), Public Health Information System (PHIS), and the National Notifiable Disease System (NNDS). Taken together, these systems perform functions of an effective surveillance system: tracking health and burden-of-disease metrics; detecting, reporting, and investigating notifiable diseases, events, symptoms, and suspected outbreaks; and submitting timely, complete reports. These systems are largely electronic but with limited interoperability and interconnectedness. The different systems are not unified, with vertical program surveillance systems for recording and reporting organized around specific conditions. Moreover, nursing stations still rely on paper-based mediums and the various surveillance systems are not integrated. The usefulness of the data collection systems relies on regular, good-quality data entry by frontline workers, and challenges remain in terms of accessibility at the PHC, subdivisional and divisional levels with lack of transparency within the EWARS systems. Integration of several separate systems is risky, with significant risk regarding data quality, particularly if the systems do not present time savings or facilitate the work of frontline users responsible for data entry.

National priority setting is devolved to programs or units, which develop their own priorities, with limited cross-cutting targets or accountability for achieving collective health system results. There is

broad interest across the MHMS to leverage data for decision making, but lack of staff dedicated to collating, cleaning, and analyzing comprehensive data in a timely manner make it difficult to achieve. Use of data for priority setting depends on individual champions who proactively request data or have their own vertical data collection systems. Without standardization in the priority-setting process, it is challenging to ensure that priorities are rooted in and reactive to data on population health needs. Stakeholders are engaged in most priority-setting exercises, although this engagement occurs with variable methods, structure, and composition because stakeholder involvement is often program-based—particularly for activities at the subdivisional level. There are limitations in resource allocation, with strict budget proposal requirements and few flexible funding options. The MHMS does not fund all programs, but government processes can be used to make donor funding sustainable. The system is based on budget priorities and predefined activities, with partners stepping in to fill gaps.

Fiji's culture of collaboration within the village setting has resulted in an ecosystem of innovations in the delivery of health care, but nascent mechanisms to support dissemination and lessons learned limit broader uptake across PHC settings. Mechanisms to recognize, evaluate, and scale successful innovations are in their early stages and often rely on individual champions or relationships. Recognition and scaling of innovations can come from various sources, including programs, external funders, regional reviews, or lobbying efforts. Criteria for evaluating innovations vary, and there is no formalized, systematic, or transparent mechanism for evaluation. Successful expansion of innovations largely depends on champions navigating the system effectively, and the only established mechanism for continued scale is through the strategic and annual operational plans, which program focal points typically review and incorporate and rigid budgets and competing priorities constrain. Despite limited supportive systems for evaluation, recognition, or expansion, innovations do occur, with examples including community-based surveillance and mobile

reporting by community health workers (CHWs). As a result, relevance, impact, and scalability can vary.

Box 3: Deep Dive into Governance and Gender

Gender-informed primary health care (PHC) governance ensures that the PHC system is responsive to the needs of all individuals, regardless of gender. It recognizes that gender influences health outcomes and that health systems must be designed to address the different needs of individuals. Gender-informed governance can help ensure that PHC services are accessible, affordable, and of high quality for all individuals through policy formulation and effective implementation strategies of specific, targeted health interventions.

Fiji's health policies and plans demonstrate a strong commitment to gender-responsive considerations that encompass PHC, despite the absence of a clear PHC definition. These policies, which include the National Gender Policy, Rights of Persons with Disabilities Act 2018, Women's Plan of Action 2010-2019, and 2014 Reproductive Health Policy, emphasize provision of high-quality preventive, curative, and rehabilitative health care services tailored to the needs of vulnerable populations, including children, adolescents, individuals with disabilities, and pregnant girls and women. The Women's Plan of Action addresses discrimination against women and outlines essential services for women and girls who have experienced violence, including referral to and treatment at appropriate facilities and proper documentation. The 2014 Reproductive Health Policy tries to ensure that adolescents and youth have access to services regardless of their sex or gender. These policies is prioritized health care worker training to address gender-related issues and provide gender-sensitive services, but gender-related policies lack detailed implementation strategies within the PHC system and rarely specify health care service packages for women or particularly vulnerable groups. Like many PHC activities and interventions, gender-responsive considerations within the PHC service package are addressed through vertical programs, but more-comprehensive, -integrated implementation strategies are needed, particularly for interventions in gender-based violence (GBV), sexual and reproductive health, and family planning. For example, despite the goal of

the National Strategic Plan 2016-2020 to expand provision of preventive and clinical services and youth-friendly health care services for 13- to 24-year-olds and its emphasis on standards of gender equality, privacy, confidentiality, and competent health care providers, only 3 percent of facilities offer adolescent- and youth-friendly services. Although national health plans and strategies focus on GBV services, implementation is not systematic, and only 4 percent of facilities are considered GBV service ready. In contrast, family planning services in Fiji, which are largely gender responsive, recognizing the unique needs and inequalities which patients face, are integrated into the essential sexual and reproductive health care package, which also covers maternal and newborn care, HIV and acquired immunodeficiency syndrome prevention and treatment, sexually transmitted infection care, post-miscarriage services, GBV detection and counseling, and cervical cancer prevention and treatment. Efforts are underway to strengthen health care services and referral pathways for GBV survivors by developing clinical guidelines and health care worker training.

Without a coordinating authority focused on managing gender and women's rights issues and budget allocations, fragmentation of Fiji's PHC system and lack of clarity in leadership extend to coordination of gender-responsive interventions in PHC. There are authorities with a mandate to address gender-related issues, including the Ministry of Women, Children, and Poverty Alleviation (MWCPA) and the Fiji Women's Crisis Centre (FWCC). Although the ministry serves as the coordinating authority, its influence on health care services is limited and requires effective collaboration with the Ministry of Health and Medical Services and other ministries. MWCPA budget allocation for implementation of policies and standard operating procedures is unclear in the national plans, which may influence how ministries fulfill their gender and women's rights management responsibilities. However, as part of Fiji's Public Financial Management Improvement Plan (2021-2024), a phased approach to gender responsive budgeting was implemented to ensure that gender gaps are addressed in sectoral budget allocations. This initiative includes the collection, analysis and reporting of gender disaggregated data to inform resource allocation within each sector. Ministry of Health and Medical Services is one of the ten ministries included under this initiative for the 2023-

2024 budget process. The FWCC also plays a vital role in addressing gender inequality and violence against women, offering services such as GBV support, sexual and reproductive health services, crisis counseling, safe housing, and police assistance but its authorities seem limited and the government budget allocation to FWCC is unclear.

Limited coordination among nongovernmental organizations, civil society, and local grassroots organizations in addressing gender issues during community engagements contributes to fragmented systems of social accountability regarding gender and PHC. A few organizations involved in expanding PHC interventions do not prioritize gender issues, which contributes to the insufficient collaboration between partners when developing gender-related policies. Use of disaggregated gender data to promote gender-responsive policies is inconsistent and insufficient overall, primarily focused on the prevalence of violence and lacking comprehensive gender indicators for PHC systems. The lack of consistent gender disaggregation of health data indicates the need for more-comprehensive and strategically implemented gender data to promote policies with gender-responsive considerations and improve health care services for all.

INPUTS

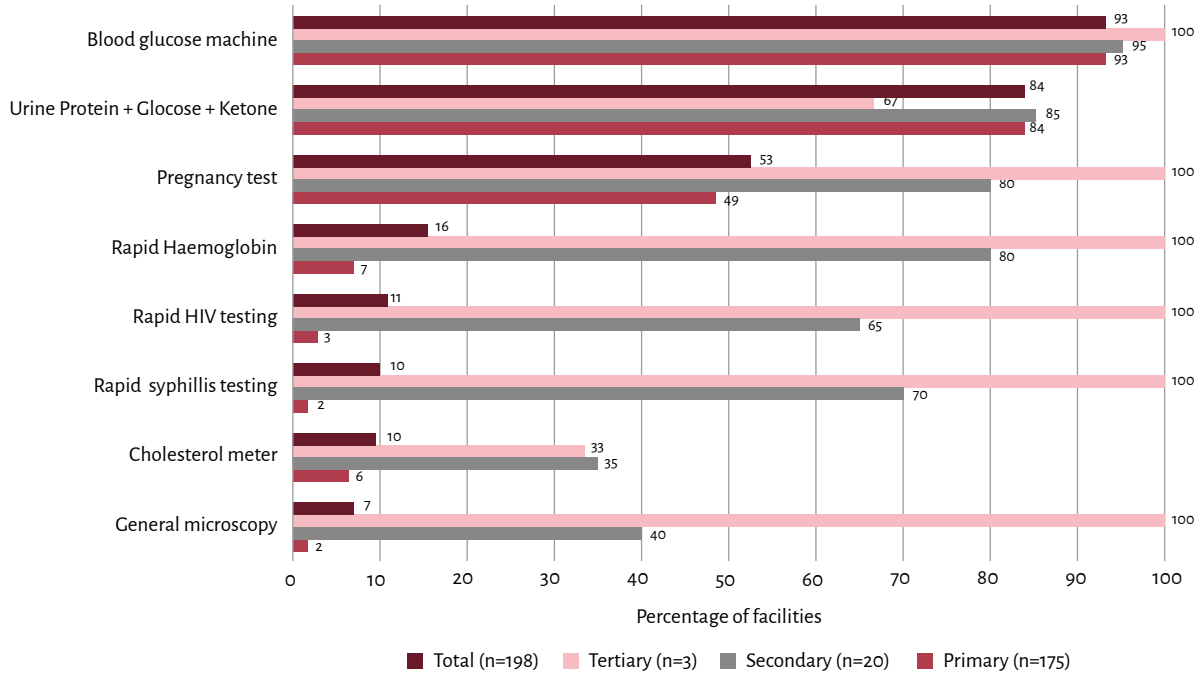
Measurement of input availability helps identify gaps and distribution of resources required to deliver timely, appropriate, high-quality PHC services to enable decision makers to better allocate resources and increase access to PHC services.

Availability of medicine and consumables in PHC facilities is limited. Fiji's essential medicines list aggregates the medicines and consumables that are supposed to be available at various types of facilities, with nursing stations supposed to have fewer types of medicines than health centers by

design. Survey data from the 2021 SARA survey evaluated availability of family planning supplies and medicines to treat STIs and found that only 2.1 percent of facilities had all items available. On average, PHC facilities had 60.6 percent of family planning supplies and medicines to treat STIs available, highlighting significant variation between availability of different types of drugs and diagnostics. Vaccines are more readily available, with 37 percent of facilities having all vaccines available.

Although most PHC facilities have the necessary basic equipment, only 2.6 percent have all of the diagnostic equipment needed to deliver comprehensive PHC. Availability of diagnostic equipment is assessed according to the presence of supplies needed to conduct all necessary diagnostic tests: rapid hemoglobin; blood glucose; urine dipsticks for protein, glucose, and ketones; urine pregnancy tests; rapid HIV; rapid syphilis; and cholesterol. Data from the 2021 SARA survey reveal variations in availability of different types of tests that make it difficult for facilities to provide comprehensive PHC services. Certain diagnostic tests, such as blood glucose (95.7 percent) and urine dipsticks for protein, glucose, and ketones (88 percent), were readily available, but availability of rapid diagnostic tests was variable at the PHC level, requiring that patients visit secondary and tertiary health care facilities for some tests. The significant variation in diagnostic supplies between facility types and divisions suggests that there may be challenges in distribution and procurement that limit delivery of high-quality PHC. Despite limited availability of medicines and diagnostic tests, 88.1 percent of facilities had all basic equipment (adult weighing scales, infant weighing scales, blood pressure apparatus, tape measures, thermometers) available, with some variation between facility types; 88.6 percent of PHC facilities had all basic equipment, and all secondary and tertiary facilities had all basic equipment available (Figure 13).

Figure 13. Availability of Rapid Diagnostic Tests According to Level of Health Care



Source: SARA 2021

Efforts to ensure access to care have increased availability of facilities across Fiji's varied geography, but uneven distribution in terms of population size has led to some PHC facilities being responsible for large populations. Ensuring that all populations have good geographic access requires sufficient infrastructure, which can be enabled through an assessment of PHC density and distribution, documented targets, and action taken to ensure that targets are achieved. Fiji has many of the substrates needed to address facility density and distribution strategically. A list of PHC facilities and their locations is maintained, and the ideal population catchment areas for various facility types have been identified using role delineation (Table 4), and the strong civil registration and vital statistics (CRVS) system, described below, provides accurate population numbers. Ratios of the poputhe population to facilities show that few divisions meet the ideal population catchment size (Table 5). PHC facilities in the Eastern and Northern divisions serve catchment populations that are

relatively well aligned with targets, whereas facilities in the Central and Western divisions are significantly overburdened—particularly in urban areas and informal settlements. Facility counts show that there is a high number of facilities across Fiji, including in rural and remote areas. Some facilities in rural and remote areas, particularly in the Eastern Division, have low usage rates while benefiting from a high staff-to-population ratio. When population size is considered, PHC facilities in urban areas are particularly stretched (e.g., 1 nurse per 40,000 people in the Raiwaqa health center in Suva). Access to and quality of care may be limited in these facilities, with demand leading to long waits, short visits, and insufficient supplies. The ratios and facility mapping have not been adapted to serve as specific targets for facility construction, improvement, reclassification, or closure across all divisions and facility types. The large number of facilities and geographic distribution across geographically remote and hard-to-reach areas constrain resources, as reflected in the small number of facilities with access to all amenities (15.3 percent) and standard safety precautions and equipment (20.1 percent). Particularly salient for digitalization of information systems, 63.8 percent of facilities had access to the Internet, and only 41.7 percent had a laptop, desktop, or tablet, according to the SARA 2021 survey.

Table 4. Defined Catchment Populations According to Facility Type

Facility type	Ideal defined catchment population size
Health center A	>15,000
Health center B	10,000–15,000
Health center C	5,000–10,000 + outreach to communities < 5000
Nursing station	<1,000

Source: Fiji Role Delineation Project Report 2019.

Table 5. Average Population per Health Care Facility According to Type of Facility and Division

Division	Population	Divisional hospital		Subdivisional hospital		Health center		Nursing station		All facilities	
		Number	Average population per facility	Number	Average population per facility	Number	Average population per facility	Number	Average population per facility	Number	Average population per facility
Central	378,284	1	378,284	6	63,047	22	17,195	23	16,477	51	7,417
Western	337,041	1	337,041	5	67,408	29	11,622	26	11,963	60	5,617
Northern	131,914	1	131,914	3	43,971	20	6,596	21	6,282	44	2,998
Eastern	37,648	0	-	5	7,530	15	2,510	31	1,214	51	738
Total	884,887	3	294,962	19	46,573	86	10,289	100	8,849	205	4,254

Source: Fiji Master Facility List; CRVS data 2012-2017

Fiji has a strong CRVS system, capturing more than 90 percent of births and deaths. This system generates administrative data that serve as the basis for databases and population registers and are essential for effective health care planning and service delivery. A slightly higher percentage of deaths (96 percent) are registered than of births (93 percent). Providing incentives for death registration has increased the percentage of deaths captured; the medical certificate of cause of death is essential for registration of death and for succession. The CRVS system provides a strong foundation for efforts to establish a master patient registry and extend the practice of identifying catchment populations into a system of empanelment (assigning patients to individual primary care providers and care teams with sensitivity to patient and family preference).

The health management information system (HMIS) has several components, including the Patient Information System (PATIS-plus), a digital integrated personal care records system and information system available at the area health center level, and the Consolidated Monthly Return Information System (CMRIS), a paper-based registry used in nursing stations and reported monthly, and is collectively in place in more than half of PHC facilities. Fifty-five percent to 60 percent

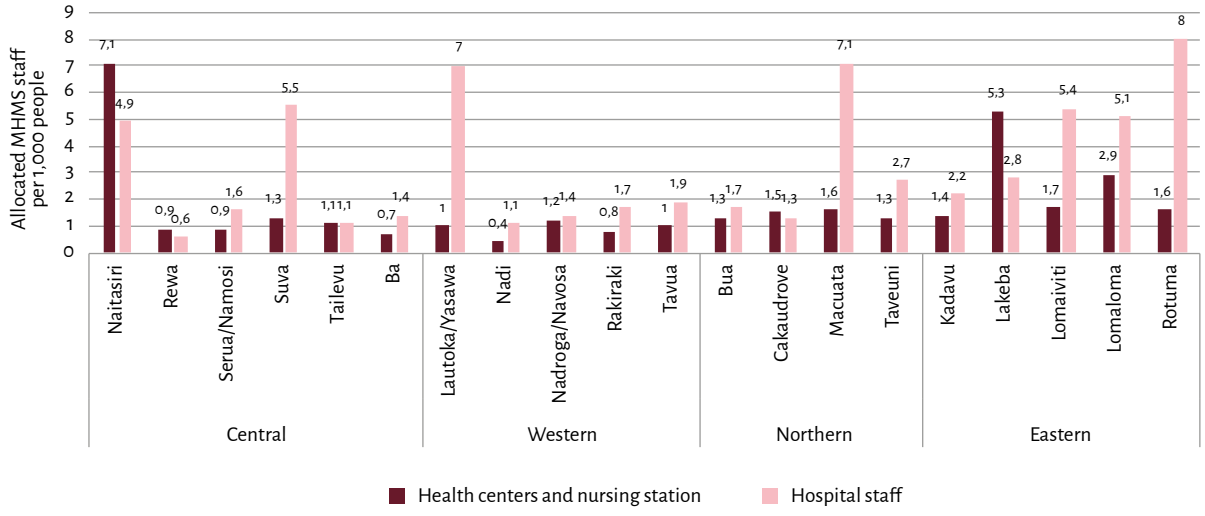
of facilities have access to PATIS-plus, and nearly all nursing stations use CMRIS. There are high reporting rates for CMRIS, but its paper-based nature requires forms to be sent and uploaded to the digital system before they can be integrated—a time-intensive process. Challenges such as system inaccessibility and outdated information technology hinder efficient data management, including backing up data and ensuring connectivity. Efforts are underway to enhance the HMIS, improve system interoperability, and introduce a master patient index to streamline information sharing and processing across facilities.

Fiji's PHC facilities maintain personal care records, which are mainly paper based and are disposed of after five years. These records contain various components, including unique patient identification numbers, problem lists, care history, medication lists, allergies, referrals, results, and laboratory and test results. The extent of use and interconnectivity of these records varies between facilities and health information systems. The unique patient identification number is not integrated into the CRVS or PATIS-plus systems, and individuals may have many identifications within and across these systems. Although not in most PHC facilities, there are digitized personal care records that provide a strong foundation for expansion across the PHC level. PATIS-plus contains comprehensive patient-level information, but it is available only in type A and B health centers. Tumanu, a system that the mSupply Foundation developed, is another application used for electronic health records and includes patient identification numbers, problem lists, care history and notes, medications, allergies, referrals, and test results.

Workforce is an acknowledged challenge for the health sector, with challenges in overall workforce density and staff retention. Fiji has 3.7 health care workers per 1,000 population, below the Sustainable Development Goal threshold of 4.45 (Figure 14) and insufficient to provide the broad range of PHC services needed to achieve universal health coverage. The number of allocated health worker positions in the MHMS

is enough to exceed the Sustainable Development Goal, and if staff were recruited and retained, the ratio would be 4.75 health workers per 1,000 population. Health clinics and nursing stations are inadequately staffed to deliver effective preventative and follow-up care and may benefit from expanding staff in urban health centers and the number of adequately trained CHWs. A range of factors, including limited promotion pathways; remote working conditions; recruitment into the growing private sector; and the high demand for trained nurses and doctors in nearby larger, more developed markets such as Australia and New Zealand, exacerbate Fiji's health care workforce challenges. In some cases, these factors cause health care workers to leave the field. These challenges have wide-reaching impacts, affecting provision of health care services, data analysis and use, and equipment maintenance in the PHC system. Efforts to recruit and retain health care staff are recognized as essential to address the current workforce shortage and achieve greater coverage for health care services.

Figure 14. Allocated Ministry of Health and Medical Services Staff per 1,000 People According to Facility Level



Source: MHMS 2023

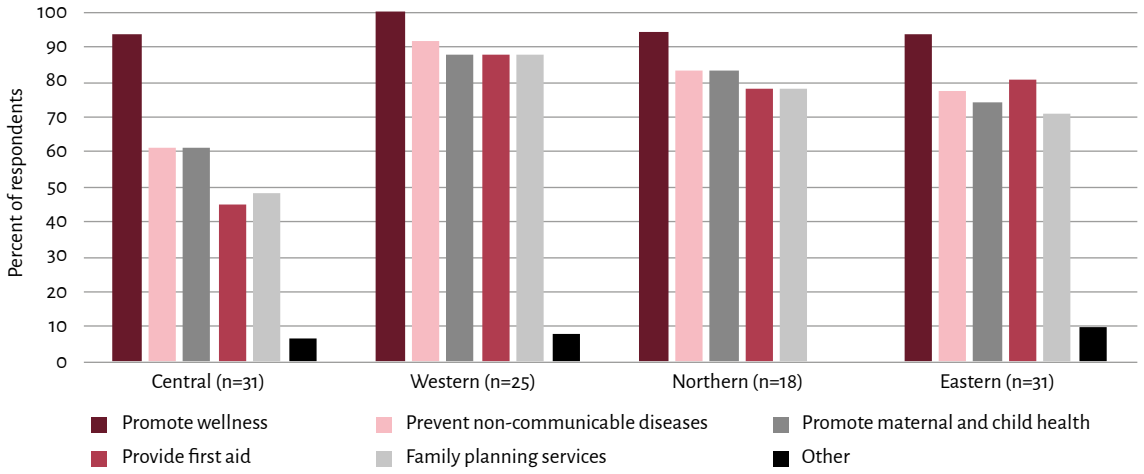
Fiji has well-established quality assurance mechanisms for its PHC workforce to ensure that health care professionals meet the necessary qualifications and maintain high-quality standards in their practice. The medical, nursing, and dental councils are responsible for setting and enforcing standards to ensure that health care workers have the required qualifications and adhere to quality standards. This includes ongoing professional development and mechanisms for addressing complaints. The MHMS has mechanisms to ensure that all practicing PHC workers are qualified, and this applies to local and foreign credentials, including annual registration and participation in continuing professional development programs. The quality of the PHC workforce is continuously assessed through annual performance assessments and clinical governance evaluations.

PHC workforce competencies are established for all occupations and include most of the elements of high-performing workforce competency systems. They are evidence based and adapted to the regional and country context, and standards of education based on competencies relevant to PHC have been set for all occupations, although competencies could be further tailored to ensure that they are relevant to PHC, meaning that they incorporate all key functions of PHC: first-contact access, continuity, comprehensiveness, coordination, and people centeredness. The high standards of competencies and qualifications for the workforce in training and quality assurance are not always aligned with what health care workers are allowed to practice; limitations on the services that they are allowed to practice, which fall below the level they are trained at, constrain much of the workforce. This may contribute to some challenges in workforce retention and higher numbers of patients seen at secondary and tertiary care facilities for conditions that could be treated in theory, but not design, at the PHC level.

In Fiji, CHWs have well-defined roles that focus on proactive population outreach and community health promotion and are

functioning across all geographic areas. CHWs are primarily responsible for working with community leaders and community members to promote wellness, reduce illness, and address public health concerns. Although they do not perform clinical procedures without supervision, they provide basic PHC, particularly in hard-to-reach areas where access to medical services is limited. Findings on regional differences in CHWs' perceived roles suggest that CHWs are responsive to and supplement services provided in health centers and hospitals in each region (Figure 15) (Yoon et al. 2019). For example, CHWs in the Central division spend more time promoting wellness, maybe because patients can access other services from facilities more easily than those in the other regions with more geographically disparate facilities. CHWs receive standardized training for at least six weeks, equipping them with core competencies for their role. Their training covers a range of health topics, including maternal and child health, infectious iseases and NCDs, and emergency first aid. Communities select CHWs, who are not formally accredited, although there is a growing consensus that establishing accreditation or certification for CHWs could provide clarity and ensure that they are supported to function within their defined scope of practice. CHWs also have supervisors and are integrated into the local health care facility service delivery system. They are expected to maintain contact and share information with nursing stations and health care professionals, facilitate referrals, and promote health promotion in communities. Although they have a substantial data-gathering role, there is limited evidence of active use of the data collected. CHWs are formally employed and remunerated based on submission of reports, which has introduced some delays in payments. CHWs' accomplishments have been celebrated, and there is further opportunity to expand their role; the CHW model underserves rapidly growing urban populations, particularly those in formal and informal settlements.

Figure 15. Community Health Worker Perceptions of the Roles They Are Expected to Fill



Source: Yoon et al. 2019.

Facility budgets are maintained at the central level for more than 90 percent of PHC facilities, and divisions are aware of each facility's budget. Budgets are expense based, and information from previous financial years is used to forecast for the upcoming year, but challenges in disbursing budgets mean that they are "first come, first served," and funds come from a mix of division-level budgets, with breakdown to the facility level. Programmatic budgets are held at the central level. There is interest in decentralizing authority and accountability for facility budgets, with minor tweaks being made as a quarterly program to refine the design and introduction of decentralized budgets. There is limited systematic forecasting, with some facilities using previous years' data to project expenses. The level of understanding of and knowledge about facility budgets can vary, creating challenges in forecasting for efficient resource allocation and planning at the facility level.

Box 4. Overview of Information Systems and Funding Mechanisms for Noncommunicable Diseases (NCDs) in Fiji

Data on NCDs are routinely collected and used for decision making, but this has not been translated into budget security for NCD activities. The Ministry of Health and Medical Services (MHMS) and Wellness Division routinely collect and use data to determine priorities, including using routine surveys such as the National Nutrition Survey, Oral Health Survey, and STEPwise approach to NCD risk factor surveillance. PHC facilities also regularly collect data on NCDs through several systems, including the Consolidated Monthly Return Information System for cervical cancer screening and the Patient Information System for hypertension, diabetes, and rheumatic heart disease at specific health centers. There are also dedicated registries at PHC facilities for tracking people with diabetes, but they do not track cases longitudinally or aggregate information on quality of care. The Wellness Division receives a budget allocation for activities related to NCDs specified in the National Wellness Policy, which focuses on health promotion. Outside of the activities specified in the National Wellness Policy, this analysis identified that the funding mechanism for implementation of the Package of Essential NCD Services and other NCD activities that the MHMS provides is not well understood. Budget allocation is insufficient for the MHMS to provide NCD services effectively, and it has been suggested that budgetary decisions and allocations are ultimately determined politically.

The Ministry of Finance manages Fiji's financial management information system (FMIS), and the MHMS uses it at the subdivisional and divisional levels, but it is not accessible for use at the facility level, including health centers. The system includes staffing, line item budgets, and internally generated funds (including revenue from service users) at the national and divisional levels. Expenditure information is captured from divisional offices, but it is unknown whether the MHMS can estimate expenditures at the specific health center or cost center level.

Remuneration of PHC staff is relatively straightforward and includes two categories—established staff governed by the Public Service Act and

un-established staff whose conditions are outlined in the Joint Industrial Council Agreement. Payment mechanisms for salaries are stable and predictable, with staff consistently receiving the amounts specified in their contracts or employment agreements. The Government of Fiji's Job Evaluation and Civil Service Remuneration Guideline and the General Orders of the Public Service Commission define salaries and allowances for different staff cadres. There are variations in allowances based on cadre and geographic location that may affect the PHC workforce, particularly in terms of outreach activities. PHC staff are typically paid on time according to their contracts, which specify the timing of payments—fortnightly or weekly. CHWs are not always paid in a timely manner because of the requirement that they submit reports before payment. There are variations in allowances between different cadres of PHC workers, with facility location and staff roles influencing allowances.

Box 5. Deep Dive into Inputs and Gender

Gender -responsiveness of primary health care (PHC) service inputs covered in this section can help ensure that health care providers are trained to provide gender-sensitive care and that quality assurance mechanisms identify and address gender-based disparities in health care access and outcomes. Gender is an important consideration in inputs such as quality assurance mechanisms and data quality. As noted above, data are not generally disaggregated according to gender, and there is opportunity to expand their utility in ensuring effective PHC services.

Quality assurance mechanisms promoting a PHC workforce that is gender-sensitive during service delivery are limited. Training is the primary method used to achieve this goal. Many training programs for Fiji's health care workforce are designed to ensure that quality assurance mechanisms promote gender sensitivity in service delivery, particularly in addressing gender-based violence (GBV) and sexual and reproductive health. The National Service Delivery Protocol, introduced in 2019, is designed to ensure provision of appropriate, good-quality services for survivors of GBV. It includes guidelines for various

aspects of service delivery such as referrals, counseling, case management, and survivor advocacy. To ensure the quality of these services, a GBV training program has been implemented that provides capacity building for service providers. By early 2020, more than 200 individuals from various organizations, including police officers and health care workers, had undertaken this training. Stakeholders have also incorporated gender-sensitivity training into various work, such as the collaboration between organizations like Diverse Voices and Action for Equality and the Fiji Women's Crisis Centre to provide training on GBV. More than 2,500 people from 13 sectors including health and education across the country have participated to their programs. The Reproductive and Family Health Association of Fiji conducts sexual and reproductive health rights training, targeting young leaders with disabilities and children in special schools. A training manual for sexual and reproductive health that provides essential skills, equipment, data collection tools, and communication resources to increase access to contraception is also under development. These initiatives demonstrate a commitment to leveraging training mechanisms to enhance gender sensitivity in service delivery.

POPULATION HEALTH AND FACILITY MANAGEMENT

Fiji is implementing measures to ensure effective population health management in the PHC system, largely in rural areas, with opportunity to increase the scope and impact of population health and facility management activities. Population health management measures assess how well population health is managed, including activities such as community outreach and local priority settings. Facility organization and management measures capture management capability and leadership, information system use, performance measurement, and team-based care within facilities. These two domains of PHC ensure that care delivered in local clinics and communities is proactive and based on the needs of the populations being served and that facility staff are empowered to deliver high-quality PHC.

Although subdivisions are involved in local priority setting through submission of annual plans to the division, their decision making depends largely on higher-level priorities, and they have limited autonomy and capacity. This reflects a largely top-down approach to priority setting, with local priorities flowing from program coordinators and divisional medical officers down to subdivisions, rather than up from facilities and communities. Data are used to a limited degree to translate national and divisional policies into local priorities and action plans. Documents reviewed and experts interviewed indicated that approximately half of subdivisions use data effectively for this purpose. Limited data accessibility, with restricted scope in information data conveys, makes broader use of data in local priority setting difficult. On a more regular basis, command centers are expected to analyze data weekly and identify weekly priorities, but insufficient human resources constrains their capacity to address all community needs. This process is not consistently implemented in all centers. When data interpretation occurs, community and local leader involvement is minimal; communities may be informed of relevant data and resulting priorities but are given few to no opportunities to provide input. CHWs are expected to facilitate community engagement in priority setting, but the implementation and impact of this approach are unclear. This lack of community participation in health care planning is primarily because planning is conducted at higher levels and then imposed down and to a limited extent at the facility level but without community involvement. In addition, requests from communities may not be responded to in a timely manner, indicating limited consideration of community needs in the planning process.

Nascent efforts to engage communities depend on individual communities' characteristics or the presence of highly motivated champions in the local health care system. Fewer than 25 percent of subdivisions regularly solicit input on design, financing, governance, and implementation of PHC from diverse members of the community. When they do, engagement is typically during programmatic activities. Although

some channels, such as community health committees, complaint lines, and community gatherings, are available for community input, the extent that they are used is unclear, suggesting limited use or impact on the health system. In some communities, health committees hold council meetings with community members and health care workers to address things that are not functioning well, but there do not appear to be established feedback mechanisms. These committees engage in community profiling, and plans are based on needs identified, fostering a bottom-up approach. The impact of such community engagement on service structure and delivery is inconsistent, with feedback leading to some changes but requiring further improvements in coordination and engagement. There is limited coordination among various stakeholders and partners, with each program tending to have its own outreach efforts. When community engagement occurs, it has limited impact on how services are structured and delivered. Community input has led to some changes in service delivery, but consistency and better coordination in community engagement are needed. Use of overly technical language and communication strategies that may not be well understood, potentially leading to mistrust between health care facilities and communities, are barriers to effective engagement.

Empanelment is practiced in some rural areas, where nursing stations are more aware of their patient panels thanks to CHWs and health committees. Evidence reviewed and expert input suggest that approximately 30 percent to 40 percent of communities are empaneled, particularly in rural areas. Some portions of the population are empaneled based on specific diagnoses, but challenges in coordinating and effectively delivering services to these empaneled patients persist. In urban areas, this process is challenging and is not systematically implemented; urban areas have few nursing stations and CHWs, so health care workers are unfamiliar with the communities they serve. In those areas, factors such as travel convenience and affordability, rather than empanelment, influence patient choice in accessing health care services. This results in individuals bypassing

local services in favor of more comprehensive options in different areas and limited continuity of care because the facilities and health workers where patients seek care may not know them. There is broader understanding of the general catchment population sizes each facility serves. Although there are administrative structures for catchment areas, they are not consistently used to establish empanelment, although this is a promising element that could be leveraged for establishing empanelment practices across the country.

Current population outreach activities are conducted predominantly in rural areas and serve as a strong foundation for conducting proactive, evidence-informed population outreach. In rural areas, in roughly 40 percent of subdivisions, outreach activities are conducted as part of PHC services. This includes mobile clinic teams for services such as cancer screening, rheumatic heart disease clinics, and HIV community awareness campaigns conducted primarily by nurses. The frequency and coverage of these outreach activities vary across subdivisions, and it is unclear which clinical or community needs they address. Subdivisions have defined zones that are used for profiling, and registries with patient information are regularly updated, but disease-specific registries are not integrated for more comprehensive outreach. For example, there are registries for conditions such as diabetes, cancer, and rheumatic fever, but they are centralized and primarily used for monitoring incidence and prevalence at the national level. These registries, although updated, are not consistently used to facilitate proactive population outreach and direct the types of services delivered to specific populations at specific times. This limits their applicability and the effectiveness and efficiency of those efforts in targeting community health needs. CHWs play a role in these efforts, being encouraged to create contact directories or conduct community profiling that could be expanded to include individuals with specific health needs for proactive population outreach. To activate further proactive population outreach, challenges will need to be addressed, including limited

transportation, staff shortages, data overlap and duplication, coverage gaps, and flaws in information systems that affect facility service delivery during outreach activities.

Team-based care, a strategic approach to distribution of work among members of a PHC practice team, is implemented in fewer than half of PHC facilities and varies according to region and facility type. This approach is more formalized in specialized care settings than in PHC, with some mandates for team-based care regarding specialized services and in hospitals. Forums for data collection and case discussion foster open dialogue and clinical team collaboration, but there have not been explicit, standardized, sustained efforts to implement or encourage team-based care at the PHC level. When team-based care is provided, implementers and individual champions initiate it independently. This is more prevalent in rural areas, such as the Eastern division, where departments collaborate to share resources in response to health challenges. In the Western division, innovative approaches to team-based care are being developed in response to workforce challenges. For example, medical officers from health care centers provide guidance to nursing station nurses, enabling them to offer services beyond their usual scope. Existence of these ad hoc and limited practices of team-based care at the PHC level indicates interest in standardizing, supporting, and expanding this element of facility organization and management and potential opportunity to do so.

PHC facility managers face several challenges in managing PHC facility operations and staff, and few managers have formal training or regular supervision to support them. Formal training in facility organization and management and supportive supervision covering management practices can help PHC facility managers administer and manage facilities effectively in addition to providing clinical care. Fewer than 25 percent of medical officers and nurses who run PHC facilities receive official management training. Although nurse training includes leadership and management, this is a small part of the coursework and is not consistently applied. There are master's degrees with coursework that includes aspects

of management, but it is uncommon for PHC facility managers to have a master's degree. In practice, nursing station and health center managers learn management skills through experience, with limited coaching or supervision. This presents challenges, because the facilities are staffed with one or two health care workers and therefore provide limited opportunities for new graduates to pick up managerial skills from more experience colleagues. Annual reviews and feedback on management capabilities and performance are not consistently provided, occurring only about one-quarter of the time in most facilities.

Use of information systems in PHC facilities, including nursing stations, health centers, and clinics, varies. Data collection is largely in paper-based registers and capture counts, which offers limited information to inform patient- and facility-management activities. In terms of staff capacity to use information systems, expert input suggests a degree of skepticism regarding the ability of younger nurses to use data, despite there being a collective sense that staff generally know how to use and analyze data for reporting purposes. Unavailability of computers for accessing or conducting analysis limits information systems use, with almost half of health care workers using their personal computers. Use of data also depends on the type of information, with service use data being more commonly used and interpreted. Despite extensive data collection, the information captured does not easily lend itself to quality assessment and improvement activities in the paper-based format or the type of information captured. There are challenges related to interoperability among information systems, making it difficult to incorporate information on communicable diseases into patient care, for example. For these reasons, use of data at the PHC facility level is limited, which limits performance measurement and management activities, with fewer than 25 percent of facilities having documented quality improvement work. When they exist, performance improvement efforts tend to be focused at the subdivisional rather than the facility level.

Supportive supervision is a regular practice within health care facilities, including nursing stations, health centers, and clinics. More than 75 percent of facilities implement or receive supportive supervision, which involves quarterly supervision and audits conducted for all nurses across different levels. Nursing officers and subdivisional medical officers visit nursing stations and health care centers to assess clinic management and service delivery. When service delivery problems arise, coaching and counseling are provided to nurses. When in-person supervision is not feasible, alternative methods such as phone calls are used. In urban areas, there is a monthly report that includes the needs and requests of health care centers, and meetings are held to address and solve any problems, often followed by an action plan.

Box 6. Deep Dive into Population Health and Facility Management and Gender

Gender responsiveness of primary health care (PHC) is an important consideration in population health and facility management, particularly during efforts to engage communities and improve team-based care approach. Gender-based differences in access to and use of health care must be recognized and addressed to ensure equitable health outcomes for all individuals, especially women and girls. Women are often the primary caregivers in families and communities, and their participation in health care decision making is crucial. Engaging women in health care decision making can lead to better health outcomes for women and their families. In addition, it is important to ensure that health care providers are diverse, with inclusive teams, and trained to provide person-centered care that is sensitive to the needs of all patients, regardless of their gender. For example, people may feel more comfortable discussing certain health concerns with providers who have the same gender identity. Gender diversity can help ensure that the team is equipped to create a safe space for patients to access health information and services regardless of sex and gender.

Limited community engagement contributes to a significant gap in feedback mechanisms for soliciting input from women and girls related to service quality, satisfaction, and trust in providers. There are insufficient established feedback mechanisms between health care facilities and the community, especially for gender-specific experiences. Although the community health worker training manual acknowledges challenges related to gender inequality and PHC services , it focuses on availability and provision of services, paying limited attention to patient participation and satisfaction, including of women and girls. The Ministry of Health and Medical Services' 157 helpline, designed to address health care service concerns, is underused. Facilities also lack a structured approach to using the data collected from the helpline and the village council in decision making. This lack of feedback mechanisms and a structured approach to data use raises concerns about addressing quality and satisfaction, particularly from the perspective of women and girls. Further efforts to increase community engagement could use a gender-sensitive approach.

The current team-based approach to care does not include a nondiscriminatory gender-based approach, and PHC facilities have not implemented it. The Ministry of Health and Medical Services has tried to ensure gender representation on hospital boards and committees. For example, a majority of nurses and physicians in Fiji's healthcare workforce are women but this representation is not evident in gender-inclusive practices, which involve addressing prejudice and stereotypes based on gender in health care workers' roles and responsibilities and workplace culture rooted in traditional social roles and behaviors that are "culturally acceptable," at the PHC facility level. Although equal employment requirements exist, along with gender-sensitive institutional arrangements, there is limited concrete evidence that these measures foster a gender-inclusive health care environment. Furthermore, gender disparities in public life in Fiji raise concerns about persisting gender inequalities that may affect gender-based roles and practices on health care teams.

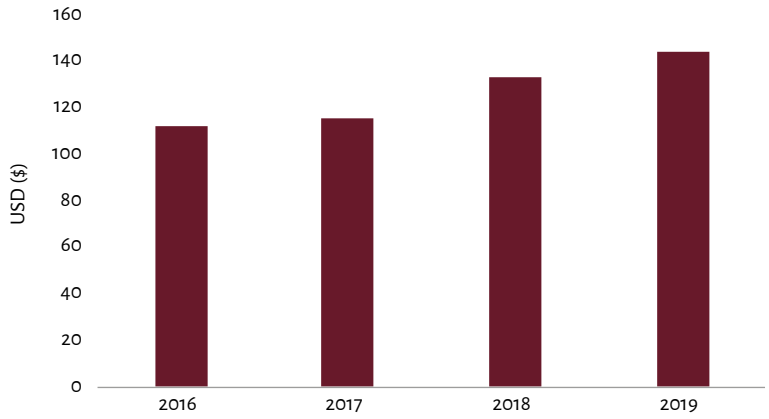
FINANCING

The financing domain assesses a country's commitment to PHC by evaluating allocation of funds to PHC and sources of expenditure. The assessment uses five indicators to evaluate total spending on and prioritization of PHC. The first indicator, current PHC expenditure per capita, examines financial commitment to PHC by capturing the absolute amount of spending on PHC per person. The subsequent two indicators focus on spending prioritization on PHC. The first is the current PHC expenditure as a percentage of the current health expenditure; this ratio captures PHC spending in relation to total health spending. The second is the domestic government PHC expenditure as a percentage of the current health expenditure. The last set of PHC financing indicators examines sources of PHC spending and includes government spending on PHC as a percentage of total PHC spending, and other spending (domestic private and external) as a percentage of total PHC expenditure.

Investments in PHC have increased over the years. Particularly striking is the expansion in per capita spending on PHC from US$112 in 2016 to US$144 in 2019 (Figure 16). Government PHC expenditure as a percentage of total health expenditure remained at 60 percent from 2016 to 2019. Expressed as a share of total health expenditure, over half (63 percent) of all current expenditure on health was spent on PHC in 2019, a slight decrease from 64 percent in 2016. Although Fiji has increased its investments in PHC services, further review of the allocation of PHC spending is required. Analysis of National Health Accounts data from 2014 to 2019 shows that a majority of Fiji's PHC budget is allocated to hospitals rather than to ambulatory or preventive care. For improved allocative efficiency and equity, the bulk of PHC services should be provided at PHC facilities and as close to home as possible, instead of secondary or tertiary facilities. Out-of-pocket expenditure accounted for 13 percent of current health expenditure,

a significant improvement from 21 percent in 2016, and per capita out-of-pocket expenditures decreased from US$36 in 2016 to US$30 in 2019.

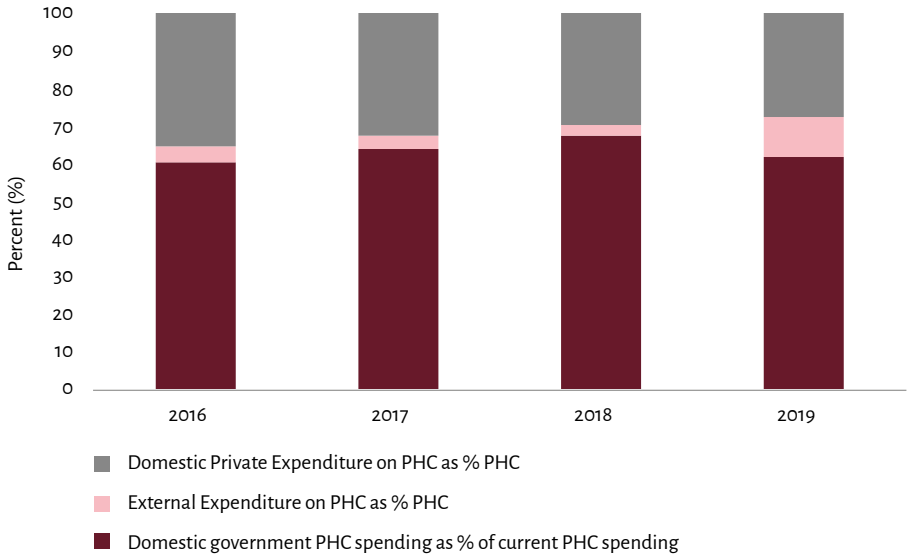
Figure 16. Current Primary Health Care Expenditure per Capita



Source: Global Health Expenditure Database 2023 (2019 data)

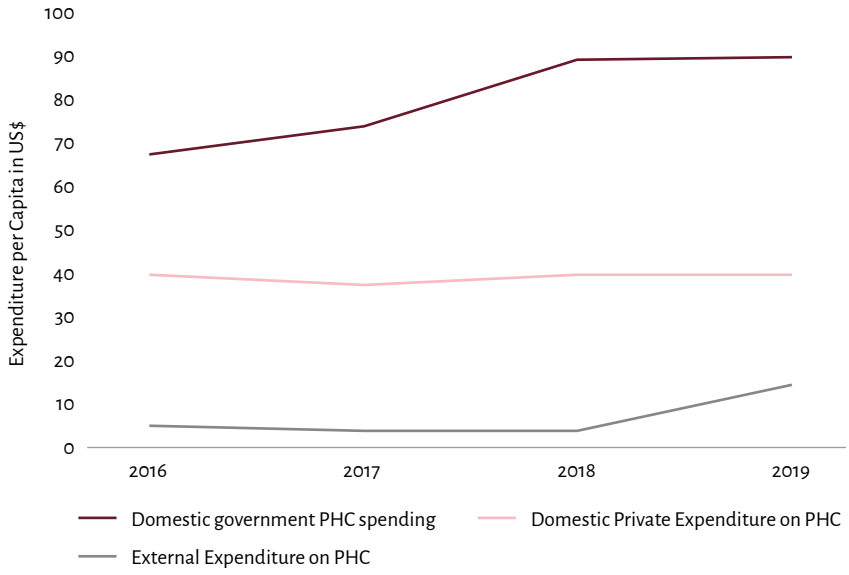
Public expenditures are the largest source of PHC financing. Analyzing sources of PHC funding shows a slight increase in the government's contribution as a percentage of overall PHC financing from 60 percent in 2019 to 62 percent in 2020 (Figure 17). Although a substantial portion of government health expenditure is dedicated to PHC, a noteworthy albeit declining proportion of PHC funding in Fiji originates from private sources. Domestic private contributions for PHC decreased from 35 percent in 2016 to 28 percent in 2019 (Figure 17). External sources as a share of total PHC spending increased from 4 percent to 10 percent (Figure 17). Trends in financing over time show an increase in per capita public expenditure on PHC. Per capita domestic spending on PHC rose 34 percent from 2016 to 2019. During this period, there were small increases in external funding, whereas domestic private expenditure remained unchanged (Figure 18).

Figure 17. Sources of Primary Health Care (PHC) Spending



Source: Global Health Expenditure Database 2023 (2019 data)

Figure 18. Per Capita Public Health Care (PHC) Expenditure by Source



Source: Global Health Expenditure Database 2023 (2019 data)

RECOMMENDATIONS

Fiji is at a critical juncture in its effort to provide high-quality, comprehensive PHC to its population and is uniquely situated to build on decades of efforts and revitalize PHC to address challenges through targeted intervention. People are living longer, and health service delivery has improved, with high coverage rates of key services such as immunization. Major challenges remain, including the significant and growing burden of NCDs and the increasing proportion of the urban population with limited access to services. Table 6 summarizes five recommendations that highlight areas that have the potential to lead to sustainable improvements in Fiji's PHC system according to priority level, time horizon, and core VSP domain addressed. A more detailed description of the recommendations, resource requirements, difficulty of implementation, potential impact, time horizon, VSP domains addressed, and suggested delegation of responsibilities is provided in Appendixes D and E.

Table 6. Recommendations According to Priority Level and Time Horizon

Recommendation	Prioritization from low (+) to high (+++)	Time horizon to impact	Vital Signs Profile domains and subdomains addressed
Implement a people-centered model of care focused on delivering comprehensive PHC at the community level by updating the package of health services and redefining the next generation of PHC personnel.	++	Long	Access, quality, coverage, capacity Governance and leadership, population health and facility management
Enhance community-based services by bolstering proactive population outreach efforts and fortifying the Community Health Worker (CHW) program.	+++	Short to medium	Access, equity, coverage Workforce Population health and facility management
Strengthen governance and leadership for PHC for effective prioritization and implementation of comprehensive primary health care as part of a broader effort to enhance accountability for achieving collective health system results.	+	Long	Quality, coverage Governance and leadership Adjustment to population health needs
Leverage the recently approved digital health strategy to enable regular analysis and application of information on PHC capacity, performance, and outcomes at facility, subnational, and national levels.	+++	Medium	Quality, coverage Information systems Population health and facility management Adjustment to population health needs
Strengthen and standardize systems for regular community engagement in PHC priority setting and accountability.	++	Short	Access, quality, equity Governance and leadership, population health and facility management

The VSP provides an overview of the state of PHC in Fiji. The above recommendations are grounded in the PHCPI framework and informed by findings from the quantitative and qualitative VSP. The Ministry of Health can use these recommendations, expanded on below, to engage with partners, with the ultimate aim of strengthening PHC services.

1. **Implement a people-centered model of care focused on delivering comprehensive PHC at the community level by updating the package of health services and redefining the next generation of PHC personnel.**

   Ensuring an equitable distribution of competent and motivated providers is crucial to meet the evolving needs of the population. A strong PHC workforce is multidisciplinary and demonstrates evidence-informed practice. In pursuit of this goal, Fiji can build its human resource capacity by enhancing the competency of PHC providers, in addition to creating a new PHC service package. This package could include support for provision of essential equipment required for service delivery.

   1.1. Define and develop new service package and delivery framework for integrated PHC.

   Developing a comprehensive package of PHC services and specifying the appropriate level of care for their delivery could enable Fiji to meet its population's diverse health needs. This approach would facilitate efficient use of care and promote delivery of high-quality services. As a first step, Fiji could convene a diverse, representative set of stakeholders including health professionals, academic institutions, regulatory bodies, and community representatives to define PHC in the Fijian context. A unified definition of PHC should include the five components of high-quality PHC systems: using PHC as a point of first contact access, promoting continuous care through ongoing patient-provider relationships, providing a comprehensive range

of preventative and curative services, emphasizing the importance of coordination within and between facilities, and prioritizing care delivery that is people-centered in its respect for patient preferences. Stakeholders can further clarify how the PHC workforce, competencies, service delivery, infrastructure, and resources will be tailored to address the requirements of each facility type and level of PHC service delivery. Fiji's role delineation work could serve as a starting point but its breakdowns of services by facility type should be carefully considered within the definition of PHC in Fiji to ensure that facilities are capacitated to provide high-quality PHC. For example, current role delineation standards allocate diagnostics to only higher-level facilities, which likely limits the effectiveness and use of lower-level PHC facilities. Fiji could establish a health care services package by following the example of the Ethiopian health system.

Ethiopia's PHC system has improved considerably during the past decade. Its essential health services package is organized into nine components that were identified through stakeholder discussion, review, feedback through a series of consultations, and analysis, and the components were incorporatd into the health care system (Ministry of Health 2019). An exhaustive list of essential promotive, preventive, curative, rehabilitative, sexual and reproductive health, maternal health, neonatal health, child health, and adolescent health services are included in the package, along with their assessed priority rankings. This was followed by a detailed implementation and integration strategy across priority areas and strategic action to improve service delivery, including reorienting the quality improvement team at the facility level on the standards of delivery of the essential health services package. The plan also included steps for training and equipping the health care workforce (Ministry of Health 2019).

The MHMS can use the EHSP tool developed in Ethiopia as a reference to plan, initiate, coordinate, and oversee priority-setting exercises. Health workers and other stakeholders can also provide feedback on the relevance, appropriateness, and feasibility of the government's decisions. Similarly, community engagement can be encouraged to ensure accountability. Stakeholders may convene regularly to reevaluate the priorities of the service package as demographic and epidemiologic needs change. Existing data could be used to identify the leading causes of morbidity and mortality within the country to guide selection of a range of preventative, curative, and palliative services.

1.2. Determine necessary workforce cadres and locations for reallocation of human resources.

Ensuring that human resources are allocated in a way that aligns with the population's health needs is critical. This involves stationing Fiji's current and future stock of health workers where their services are most needed in order to provide optimal care for the population. Fiji can use data on health workforce density, geographic distribution, and population demographic characteristics to identify the areas where workforce reallocation is necessary. These data can also help identify targets for facility construction, improvement, reclassification, or closure.

Fiji can establish clear criteria for determining population needs across divisions, considering factors such as population size, demographic characteristics, disease prevalence, and health care usage rates. Once these criteria are established, the MHMS can develop a strategy for reallocating health workers, prioritizing areas with the greatest need for health services to address gaps in access and coverage. How human resources and services are allocated during routine and emergency times should be considered to ensure continuity of care. The strategy can also include incentives to encourage health

workers to serve underserved and remote areas, including financial incentives, professional development opportunities, and good working conditions.

To support implementation of the reallocation strategy and assess the accessibility and quality of services, the MHMS can concurrently establish an M&E framework. Results from routine monitoring can be periodically reviewed to update the reallocation strategy and ensure its adaptation to changing population needs and health care trends. Data on health workforce density, geographic distribution, and population demographic characteristics are fundamental to these M&E efforts. To ensure that the strategy reflects community needs and culturally appropriate care, the MHMS can collaborate with communities at all stages of strategy development and implementation process.

1.3. Redefine the next generation of PHC personnel and strengthen their competencies.

A competent, motivated, and distributed PHC workforce underpins a country's ability to deliver high-quality PHC for all and begins with strategic policies and planning (Dussault et al. 2018). Ensuring that the PHC workforce has the necessary competencies requires appropriate education policies, programs, and opportunities, with a focus on areas such as evidence-informed practice and collaboration. To strengthen the PHC workforce to respond to the needs of the health care system, it is important to specify a human resources for health strategy that is tailored to PHC and identifies the necessary competencies, skill mix, density, and distribution of the health care workforce to deliver effective, equitable PHC services. Fiji's most recently available plan, the National Strategic Human Resource Plan 2011 to 2015, is no longer active. Furthermore, findings from the VSP suggest that current PHC workforce competencies and their scope of practice are misaligned, with health workers trained beyond what they are currently allowed

to practice. This misalignment contributes to inefficiencies in service delivery and workforce burnout.

In response, Fiji could prioritize updating health care worker competencies to ensure that the different cadres of workforce are prepared to deliver more comprehensive PHC at lower level facilities. To further institutionalize these competencies, the MHMS could work with relevant regulatory bodies to update licensing and accreditation requirements, reinforcing the updated competencies in practice. Regular reviews and updates of competencies based on feedback from providers, patients, communities, and population health data are essential. To support implementation of competency updates, resources must be allocated, including funding for training programs and infrastructure improvements. Capacity building, such as through investing in training and continued professional development programs, is crucial to ensure that health care workers have the competencies they need to meet the requirements of their assigned practice areas.

Fiji can learn valuable lessons about strengthening its PHC workforce from successful interventions such as the Vietnam Health Professionals Education and Training for Health Systems Reform Project. Vietnam has made significant investments in workforce reforms focused on PHC. In partnership with the World Bank and the European Union, the country is trying to improve the quality of education and training for the health workforce and increase PHC capacity. The Health Professionals Education and Training for Health Systems Reform Project supports a range of training programs, including modular and on-the-job training, targeting various PHC professionals. These programs are designed to align the competencies of health workers with the needs of communities and emphasize the core principles of high-quality PHC and family medicine. The training initiatives are designed to be integrated into existing education and management

structures, ensuring sustainability and accessibility at the community level. The project has also financed acquisition of modern equipment for some sub provinces to ensure that the workforce has the resources to deliver appropriate care. These efforts have contributed to development of a workforce trained in essential PHC competencies and have raised public awareness of the significance of a good-quality grassroots health system (PAD 2017; Nguyệt CM 2017; VMH 2015).

2. **Enhance community-based services by bolstering proactive population outreach efforts and fortifying the Community Health Worker (CHW) program.**

Proactive population outreach involves the active provision of care in homes or communities rather than exclusively in facilities. These services are often preventive or promotive and are initiated by the health care system rather than by patients. CHWs or similar providers most often engage in proactive population outreach, conduct health-promotion activities, educate,identify acute cases and pregnant women needing referrals to health facilities, and provide community-integrated care for common adult and child illnesses, family planning, chronic disease adherence follow-up, risk-stratified care management, and palliative care in communities or homes.

2.1. Expand comprehensive service delivery beyond health facilities through integrated, proactive population outreach in rural settings.

Proactive population outreach by clinicians at PHC facilities is an effective strategy to reach underserved populations. As an important function of a PHC system, proactive outreach can increase awareness of and access to services, increase efficiency (by moving certain health activities outside of the physical clinic), and optimize health and well-being in person-centered ways by bringing services to patients and integrating service delivery into the context of the community (PHCPI

n.d.a). Fiji has an existing practice of outreach as part of PHC services, with mobile clinic teams visiting primarily rural areas to deliver services such as cancer screening, rheumatic heart disease clinics, and HIV community awareness campaigns. There are opportunities to further improve population outreach by integrating vertical service provision into more comprehensive outreach visits, leveraging information systems to enable more proactive service delivery, and strengthening proactive outreach in urban and information settings.

Fiji can align and integrate existing outreach activities so that outreach services are delivered not according to vertical program but according to individuals and communities, ensuring that comprehensive care is delivered during each outreach visit. In practice, this would combine various outreach activities into a single trip by aligning staff, supplies, and logistics. For example, outreach in a particular community might combine cancer screening, HIV awareness campaigns, and immunizations in a single visit and would recognize that the community consists of diverse individuals who, collectively and individually, have varied health needs. This has been found to be a successful approach in other contexts, including Nigeria, which has used mobile clinics to reach rural populations with PHC services including immunization, prenatal care, skilled birth attendance, and treatment of minor ailments (Peters et al. 2020). Not only does this increase the comprehensiveness and person centeredness of PHC, but it also increases efficiency and reduces cost as travel expenses, logistical coordination, staff time, and streamlined.

Fiji could leverage its information systems to enable more-proactive service delivery by building on existing registries and HMIS capabilities to strategically direct care. Some of Fiji's subdivisions characterize needs according to zone, and this practice could be extended across all zones through standardized protocols and required reporting. Existing patient registries, such as those for diabetes and cancer,

could be made available at the subdivisional and zone level and used to direct proactive outreach efforts. Information on usage rates at the PHC facility level could be incorporated into strategic planning for proactive outreach to ensure that services are meeting community needs and supplementing or task shifting away from PHC facilities. This can have particular relevance for provision of NCD care, and Fiji could learn from efforts in Chiapas, Mexico, where CHWs conducted regular proactive outreach to support patients with hypertension and diabetes to increase access to care as part of the Acomponantes Intervention project (PHCPI 2022).

2.2. Extend proactive population outreach practices to urban and peri-urban areas to reach the growing urban population.

Fiji could leverage proactive population outreach strategies in urban and informal settings to increase access to care. Because most proactive outreach efforts are focused on rural areas, there is a gap in provision of these services in urban or informal settings which are doubly underserved by fewer available PHC facilities and staff. Proactive outreach efforts in such settings should leverage similar recommendations to integrate vertical services and utilize data to strategically direct efforts, and would likely require fewer resources for transportation. One example of urban outreach that could inform Fiji's efforts is integrated community case management work in Mali. Proactive community case management included provision of free proactive outreach services by CHWs in patients' homes and was implemented in peri-urban areas across Mali. It included five components: proactive case detection, with CHWs traveling door to door; doorstep care, including counseling, diagnosis, treatment, and referral; monthly individual supervision and weekly group supervision of CHWs from a dedicated supervisor; removal of user fees for patients who reported to CHWs that they were unable to pay

for services; and improvements to the infrastructure of PHC centers (Johnson et al. 2018).

2.3. Extend the CHW model by recruiting, training, and overseeing CHWs in urban and peri-urban areas.

Acknowledging the strain on PHC facilities, especially in urban areas and informal settlements, Fiji could implement task-shifting efforts to equip CHWs with the skills required to deliver an expanded set of services with CHWs taking on some responsibilities of urban nurses. Through task shifting, CHWs can serve as a vital link between health care facilities and the population, promoting the accessibility, availability, and provision of high-quality health services. Task shifting involves optimizing the skill mix of providers by shifting various tasks and roles across cadres of health workers. It entails reassigning responsibilities from one type of health worker to another who may have less comprehensive or extensive training but who has the competencies to deliver the particular tasks or roles. Optimizing the workforce by shifting responsibilities to cadres with greater access to communities can increase capacity and provider availability, ultimately increasing patient access to high-quality care. Fiji could invest in recruiting, training, and overseeing CHWs in urban and peri-urban areas.

A meta-analysis conducted to assess the impact of task shifting revealed that CHWs could proficiently and safely administer treatment for a wide range of diseases, including HIV, acquired immunodeficiency syndrome, tuberculosis, malaria, NCDs, and childhood illnesses. Moreover, implementing such programs demonstrated potential cost savings (Seidman and Atun 2017). Given that urban and informal areas are particularly underserved by CHWs, Fiji could focus recruitment efforts and strategically design its CHW supervision and community integration systems for these settings. Although there may be fewer traditional community structures to

leverage in the selection and support for CHWs, church groups and other forums specific to community structures in urban and informal areas could be explored. Nursing stations and health centers may play a more proactive role in urban CHW oversight given geographic proximity and different community structures from those in rural areas, with nursing stations taking on some of the functions that iTaukei may fulfill in rural areas.

2.4. Fortify the CHW model and implement task shifting to build on the successes of the existing CHW program.

CHWs in rural communities could take on a more-formal role in PHC service delivery, in addition to their health promotion and community engagement work. In other countries, such as Cameroon, CHWs have played a significant role in managing NCDs. There, diabetes and hypertension services were integrated into the essential health care package, with non-physician health care workers assuming expanded roles to deliver these interventions in rural areas. The program was evaluated over a two-year period and demonstrated good clinical outcomes for both diseases (Labhardt et al. 2010). CHWs in Fiji could be trained and deployed to provide services, with a focus on rapidly increasing urban populations, particularly those in formal and informal settlements, who the current CHW model underserves. Fiji has the potential to capitalize on the strength of existing CHW programs to expand their roles by setting clear training standards, job descriptions, and incentives and better integrating their work with providers at health facilities.

To obtain the necessary skills, CHWs should undergo standardized training, with the option for the MHMS to establish an accreditation or certification process, ensuring that the CHWs operate within a well-defined scope of practice. Establishing formal accreditation structures for CHWs would help define their role, ensure quality, provide legitimacy, and establish trust between CHWs, their communities,

and the broader PHC system that they work within. Standardized training should build on existing resources and manuals and cover a wide range of health topics, including maternal and child health, communicable diseases and NCDs, and emergency first aid. CHWs should receive adequate and timely remuneration within the public service framework, which will require close collaboration with iTaukei affairs. Adequate payment is crucial in motivating and retaining CHWs, especially in underserved areas, and the current approach results in payment delays. Developing a long-term sustainability plan for CHWs will help the MHMS ensure that they have the necessary tools, equipment, and support to perform their roles effectively. When so equipped, CHWs can become key players in extending health services beyond health facilities and providing referrals to people who require higher levels of care, encouraging proper use of the health care system. While CHWs are already integrated into the local health delivery system, incorporating the data that they collect into facility health information systems can enhance the effect of this integration on service quality and impact. This integrated approach would support regular data analysis, enabling trends and interventions to be identified and the effectiveness of public health campaigns to be tracked. Providing CHWs with designated supervisors who offer guidance, support, and clinical oversight is another key component of high-quality CHW programs. To support supervision, the MHMS could implement a CHW M&E system to assess CHW performance, including their integration into the public health care system.

3. **Strengthen governance and leadership for PHC for effective prioritization and implementation of comprehensive primary health care as part of a broader effort to enhance accountability for achieving collective health system results.**

   Governance and leadership for PHC are important for ensuring prioritization of a PHC approach and clarity in PHC across

actors, policies, and programs and for directing and overseeing implementation. Establishing a clear leadership position, increasing accountability using cross- and multi-sectoral mechanisms, and increasing collaboration through PHC-specific working groups and forums can support effective governance and leadership.

3.1. Improve coordination and clarity on PHC across MHMS entities at national and subnational levels by establishing a PHC leadership position.

Fiji would benefit from establishing a clear authority or authorities for coordinating and overseeing PHC activities. Fiji does not have an explicit coordinating authority for PHC. Instead, PHC is implicitly covered to varying degrees through programs whose remit covers some (but not all) PHC topics. This leads to varying interpretations of PHC implementation and lack of coordination at the policy and leadership level because authority is divided between divisions and programs that are responsible for their respective domains, often spanning PHC and non-PHC. For example, units such as Wellness, Health Protection, and Family Health and Divisional Medical Officers cover PHC in part. Establishment of a national entity or position to coordinate, monitor, and implement PHC policy at national, regional, and community levels could remedy the fragmentation of PHC. Development of a clear operational definition of PHC and establishment of a PHC leadership position could ensure that vertical programs, including for the treatment of NCDs, are appropriately considered and integrated into the PHC system, and the health care system in general, as included in recommendations above. Through effective stewardship and oversight, a national coordinating authority could promote effective, efficient PHC service delivery by reducing duplication and resource waste and identifying gaps in services and coverage. To operationalize this position, careful planning, consensus building, and inclusive participation from public

and private stakeholders is needed to define the scope and overall responsibilities of the position. The position holder should have sufficient institutional knowledge of the Fijian health care system and political authority to steward PHC across the many entities that currently cover aspects of PHC.

The parts of national programs and divisional responsibilities that are PHC related must be identified so that they can be coordinated. Acknowledging the decentralized nature of PHC governance and the important role that subdivisions play in PHC planning and service delivery, leadership at the divisional level should also be targeted. This could be accomplished by giving divisional medical officers a stronger focus on PHC by including in PHC leadership functions their scope of work and building evaluation of PHC leadership into their performance reviews, or by establishing a divisional PHC focal point to lead PHC efforts at the subnational level. MHMS-implemented command structures established during COVID-19 could serve as a strong foundation for decentralizing and coordinating PHC leadership at the divisional level.

3.2. Establish accountability mechanisms to help ensure that policies, strategies, and plans are translated into action and achieve desired outcomes.

Fiji could establish accountability mechanisms to support effective implementation of PHC policies, strategies, and plans. Social accountability is a measure of whether a country is held accountable to existing and emerging social concerns and commitments relevant to PHC and is important to improve health care system performance (PHCPI n.d.b). Accountability mechanisms could include M&E frameworks or key performance indicators populated with relevant data, regular reviews to track progress and identify areas for improvement, and ensuring that publications on status of PHC are publicly available. Key components to facilitate social accountability

through such mechanisms are information transparency, responsiveness to people, representative participation, and citizen-led oversight (PHCPI n.d.b). Information transparency assists in monitoring the health system and includes disclosure of relevant health indicators, budget allocation and expenditure reports, and health care system performance indicators. Responsiveness involves government institutions and actors being open and responsive to citizen voices and is enabled when stakeholders are given an opportunity to provide feedback and alternatives and to make decisions throughout the engagement process. Representative participation of important stakeholders in PHC ensures that community voices are heard and included in social accountability activities and that there is awareness and alignment across government ministries and with nonstate actors implementing and overseeing parts of PHC.

Fiji's National Strategic Plan and annual operational plans include robust M&E frameworks, but there have not been efforts to implement the M&E frameworks by compiling data for each established indicator. These frameworks break down outcomes and outputs for each objective into planned activities, key performance indicators, targets, and timeframe. By populating a result for the key performance indicators, such as in the annual operational plan, the MHMS and health stakeholders would leverage the careful efforts to construct the framework and enable assessment of implementation and impact thus far. With an understanding of which indicators speak to PHC and data on their performance, the MHMS and stakeholders would have substantive content for reviewing progress toward the achievement of objectives set out in the annual operational plan. Regular review of implementation status and achieved outcomes would benefit Fiji by allowing stakeholders to understand how inputs are translated into changes in PHC, where successes have been achieved and should be celebrated, and where additional attention should be paid. The MHMS could facilitate a system of social accountability through

regular public disclosure of the status of PHC implementation and results. Only limited materials are readily available on the MHMS website, indicating the need to make existing resources available. Investing in timely analysis of PHC implementation and results would support these efforts, populating M&E frameworks, providing content for regular reviews, and developing additional materials on the status of PHC implementation.

3.3. Strengthen collaboration between the MHMS and other important PHC actors and stakeholders through a designated PHC committee and annual multisectoral meeting.

Although the MHMS is the primary driver of PHC policy and implementation, nonstate actors such as development partners, nonprofit and for-profit non-governmental organizations (NGOs), private providers, and civil society groups are important stakeholders and are critical in achieving health care system goals of greater coverage of services and better health (WHO 2020). Multisectoral action—integration across government entities whose work intersects and interacts with PHC—is an important means of ensuring social accountability and a Health in All Policies approach (WHO 2018b).[12] The MHMS has a long history of engaging with cross-sectoral and non-governmental entities on health, with notable examples including collaboration with the Ministry of Education on healthy school policies and meal programs and a working group on water, sanitation, and hygiene.

The ambiguity and fragmentation of PHC poses a challenge to effective collaboration, introducing inefficiencies, information and awareness gaps, and potential for duplication in implementation and data collection. Building on a shared vision for PHC and leveraging

12 An approach to public policy that systematically considers the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity.

a coordinating authority, discussed above, Fiji could establish a PHC committee or technical working group with the mandate to regularly bring together cross-government and health sector stakeholders whose work intersects and interacts with PHC. Emphasis on the use of Fiji's Health Cluster could serve as a foundation for this type of mechanism. A subgroup within the cluster could be established that would meet regularly with a mandate to coordinate on PHC, or PHC-focused sessions of the overarching cluster could be regularly held. The Cluster System's Health Cluster could also be leveraged to advance the multisectoral agenda on NCDs, bringing together important actors to address key risk factors and coordinate health promotion and education initiatives. Components that facilitate collaboration through such mechanisms are representativeness, information transparency, systematic methods and structure for engagement, and opportunity for stakeholders to provide feedback and alternatives and participate in decision making throughout the engagement process (PHCPI n.d.b). Representative participation of important stakeholders in PHC ensures that community voices are heard and included in social accountability activities and that there is awareness and alignment across government ministries and with nonstate actors implementing and overseeing parts of PHC.

Fiji may take inspiration from Nigeria where, during development of its 2016 National Health Policy, the Ministry of Health built consensus with non-governmental actors by involving representatives in a technical working group that met for two years to analyze progress made on previous health care policies and chart a new way forward (Federal Ministry of Health 2016). Given Fiji's record of successful bilateral collaboration between MHMS units and nonstate actors, such mechanisms could build on these activities to institutionalize participation of stakeholders at the national level and make it more likely for them to be positively engaged and aligned with the government. This engagement promotes social accountability

and effective cross-sector and stakeholder coordination by closely involving stakeholders in planning, policy formation, and M&E due to increased and shared knowledge and systematic forums for consultation and information dissemination.

4. **Leverage the recently approved digital health strategy to enable regular analysis and application of information on PHC capacity, performance, and outcomes at facility, subnational, and national levels.**

   4.1. **Enable facility-level analysis of performance and outcome data to coordinate care, monitor performance, and drive effective management.**

   Fiji could enable facility-level analysis of performance and outcome data by bringing in additional, nonmedical human resources at the command center level to help bridge the gap between demand and supply of PHC and enable regular assessment of quality of care. Currently, the paper-based nature of data collection in nursing stations—which account for the majority of PHC facilities—limits information use at the facility level and is not readily amenable to analysis. Furthermore, these facilities do not have access to PATIS-plus or other dashboards that provide summaries of existing data. This results in low levels of information use for service delivery and performance management. There is opportunity to leverage data collection functions at or near the facility level to support high-quality PHC by introducing a new health workforce whose purpose is to analyze performance and outcome data and share results and recommendations with facilities. The command centers could serve as the base for this new group of workforce, further enabling the use of information systems in coordinating care, monitoring performance, and driving effective management. When functioning properly, facility-level use of information systems supports the effectiveness

of PHC service delivery and the ability of facilities to understand and respond to performance needs.

This could have the dual benefit of enabling data-driven delivery of services and facility performance management and shifting tasks away from clinical providers so that they can spend their limited time delivering PHC clinical services. Additional human resources would need competencies in data analysis and could be supported through the development of templates, tools, and dashboards to help generate standard summaries or visualizations in simple formats, such as Microsoft Excel. Fiji could also leverage existing communication channels to enable rapid circulation of analysis by sending the results of analyses through WhatsApp or Viber. This could help ensure that all facilities can receive their results, regardless of access to computers or MHMS intranet services. Investing in human resource recruitment, training, and equipment, such as computers and tablets, will be important for success.

4.2. Drive real-time data collection and use of information systems for performance improvement at all levels by digitalizing nursing station data collection, reporting, and analysis and establishing accessible, PHC-oriented dashboards.

By investing in the digitalization of existing information systems at the community level, the MHMS can support seamless information exchange and provide person-centered care. Nursing stations, which are the lowest level and make up the majority of PHC facilities, use the CMRIS—a paper-based form submitted monthly for incorporation into the digital information system. The resulting data and its analyses - including summary statistics, dashboards, and other visualizations - are not available in nursing stations because they can only be accessed from computers linked to the MHMS intranet. Digitalization of the CMRIS could decrease the considerable workload of manual data entry and facilitate use of information systems in the long

term. Fiji can take strategic steps in making essential investments to enhance the capabilities of the information systems by providing nursing stations with the necessary inputs for digitalization. This includes electricity, Internet connectivity, and computers or tablets, in addition to updating the PATIS-plus digital information system to accommodate nursing station data and data entry workflow. Key facility inputs for digitalization of information systems are not available in all facilities; according to the 2021 SARA survey, only 63.8 percent of facilities had access to the Internet, and 41.7 percent had a laptop, desktop, or tablet. Equipping facilities with Internet access presents data security challenges and the current approach to PATIS-plus requires installation of intranet cables, a time- and resource-intensive process. To mitigate these constraints, particularly in remote or rural PHC facilities, the digitalized CMRIS could capture only de-identified patient data, while still incorporating indicators beneficial for performance and usage analysis. This could allow for submission of CMRIS data through non-intranet mechanisms as patient data privacy is less of a concern. Digitizing a de-identified CMRIS could also open opportunities for further cross-sectoral collaboration to maximize efficiency; the Ministry of Education, for example, has a broadly implemented project enabling Wi-Fi access for schools that the MHMS could use to avoid creating additional Internet infrastructure.

4.3. Integrate and strengthen data platforms for efficient use of information to deliver continuous, person-centered PHC.

The current collection of health information systems in Fiji can be leveraged to enable performance measurement and increase the capacity of health facility, subdivisional, and divisional management to collect, analyze, and use the resulting information. These information systems include (i) PATIS-plus, a digitized HMIS with integrated personal care records that is in place in more than half of

area health centers, (ii) CMRIS, a paper-based HMIS in place in nursing stations, rural health clinics, and the area health centers that have not yet converted to PATIS-plus, (iii) paper-based personal care records, and (iv) the strong CRVS system. These information systems could be strengthened by adding data capture for indicators that enable performance and outcome measurement into CMRIS and PATIS-plus, integration and translation of data use through PHC-focused dashboards tailored to facility and subnational needs, and integration of the personal care record systems with CRVS and the immunization's master patient list to create a singular system for unique patient ids. These investments would enable decision makers at all levels to take evidence-informed action on health care and population services and optimize delivery of coordinated, continuous, person-centered PHC.

Fiji could enhance its existing information systems to enable routine monitoring of PHC quality and impact by incorporating additional indicators into its data collection and analysis processes. Robust information is key to identifying quality problems in a timely fashion and for enabling improvements or corrections where needed. The MHMS has invested in its information system and has facilitated tracking of usage and health statistics. Data can currently be used for planning purposes, maintaining essential supplies, and managing human resources because the information systems capture details on prenatal care, family planning services delivered, immunizations, integrated management of childhood illness, and medicine stockouts. There are, however, opportunities to update the data captured at the facility level to enable monitoring of PHC quality and service delivery. For example, the WHO Package of Essential NCD Services and its implementation and impacts on service delivery quality could be regularly assessed to monitor its implementation and effectiveness. This information could be aggregated from facilities to identify low-performing areas and target them with support. Although the experiences of high-performing areas can be used to help address

challenges in low-performing areas, efforts to implement balanced scorecards of performance provide a compelling example of the types of indicators that could be used and their impact on quality of care (PHCPI n.d.c). In Afghanistan, balanced scorecards included aspects such as facility cleanliness, waiting time, accurate clinical examination (based on patient volume and adequate consultation time), and proper prescribing (Edward et al. 2015). Using the scorecard performance system, stakeholders were able to identify urgent needs for allocation of resources and improve meaningful outcomes such as patient satisfaction and good-quality PHC (PHCPI n.d.d).

The MHMS could also drive real-time data collection and information systems use for performance improvement at all levels by establishing accessible, PHC-oriented dashboards at all levels. This work would align with and leverage efforts to digitalize information systems at the nursing station level because accomplishing it at scale would involve transitioning from paper-based systems to digital platforms, which can streamline data entry, reporting, and use. Fiji could create accessible dashboards at the facility, subdivisional, and divisional levels. Dashboards should be user friendly and provide relevant, real-time data visualization, making it easier for health care providers and administrators to track and monitor performance. In some countries such as Ghana, the Ministry of Health leveraged the conceptual framework of the VSP as the organizational structure of their dashboards. This supported comprehensive understanding of local PHC capacity, performance, and impact, because these topics are included in the VSP conceptual framework. Addressing facility, subdivisional, and divisional use of dashboards for evidence-based decision making will require training and capacity-building programs for health care professionals and managers, including the additional human resources at command centers referenced above. Actively promoting the use of data for decision making can further embed this approach into regular practice. Tactics to encourage providers and

administrators to use data could include requirements to cite related evidence in annual operational plans and project proposals, explicit inclusion in job descriptions and scope of work, and integration into annual reviews and supportive supervision workflows.

Facilitating interlinkages between PATIS-plus, CMRIS, paper-based personal care records, and the CRVS system will enable accurate, comprehensive performance measurement and increase the capacity of the PHC system to deliver person-centered, continuous care. Fiji has a strong CRVS system that captures more than 90 percent of all births and deaths. The country could benefit from integrating CRVS into the HMIS and patient care records to standardize tracking of individuals. By combining them together, it could help ensure accessibility to patient's comprehensive care records for informed clinical decision making. Fragmentation of the information systems and use of different patient identification numbers for each system has contributed to challenges in accuracy, efficiency, and information continuity. For example, more patients are registered in the PATIS-plus system than there are in the total Fijian population. CRVS registration numbers could provide a solution to this challenge. These integration efforts entail establishing standardized case definitions and enforcing consistent data entry procedures across PHC facilities to ensure data quality and prevent duplication (Farnham et al. 2023). They may also require addressing challenges related to system inaccessibility and outdated information technology through investments such as upgrading hardware and software, ensuring that data backup procedures are in place, and enhancing connectivity, as discussed above. Integrating with the CRVS system would link morbidity and mortality data with longitudinal patient data, ultimately enabling development of standardized quality-of-care metrics across PHC facilities.

5. Strengthen and standardize systems for regular community engagement in PHC priority setting and accountability.

Person-centered care organizes a health system around the comprehensive needs of people rather than individual diseases. This involves engaging with communities as equal partners in promoting and maintaining health and assessing their experiences throughout the health system; embedding principles of communication, trust, respect, and patient centeredness; and providing education and support for participating in health decision making. This can be pursued by introducing person-centered evaluation of health facilities and implementing processes for community-based planning. Lessons from Afghanistan's balanced scorecards, Ghana's Community Health Planning and Services program, and Costa Rica's community health boards can be translated to the Fijian context. Interventions targeted at increasing women's and girls' involvement in the health care system can also be implemented, including provision of targeted health education programs, ensuring that there are community centers and health facilities considered to be "safe spaces," and establishing minimum gender ratios for decision making bodies.

5.1. Standardize and integrate community engagement into routine population health management practices.

Fiji could establish standardized community engagement systems to support inclusion of users and community resources in all aspects of local design, planning, governance, and delivery of health care services (WHO 2017b). Community engagement is a central component of effective population health management and helps ensure that services are appropriately tailored to population needs and values. In Fiji, communities are variably engaged through ad hoc and locally specific systems. A more structured approach could be implemented to strengthen PHC services and improve population health outcomes. This could involve deep community engagement

through active mechanisms such as the formal establishment of health committees in each zone. To support this, the MHMS could develop standardized governance and reporting tools for use across all zones and subdivisions, including committee charters that record membership and leadership, define a committee's specific mission and goals, and establish routine meetings and agendas. CHWs may be a powerful resource to link the health system with community committees, and Fiji could take inspiration from Ghana's and Costa Rica's efforts to institutionalize community engagement.

Ghana's Community Health Planning and Services program is an example of how community engagement activities can be integrated into all aspects of health reform plans. The program deploys trained nurses, called community health officers, and volunteers in communities to provide preventive, curative, and promotional health activities and link with established formal community committees (PHCPI n.d.e). This helps embed health services within the community and enables the community to shape health services. In an effort to expand the program, Ghana Health Services developed an implementation guide of steps important to the program's success, including situation analysis and problem identification with district teams, sensitization of health workers to the program's model, community outreach events such as *durbars* (traditional festive gatherings), selection of sites for Community Health Planning and Services compounds, and selection and training of community health management committees (Awoonor-Williams et al. n.d.). Formalized community engagement improved the design and delivery of services, and areas with established Community Health Planning and Services programs had better outcomes than those without (Awoonor-Williams et al. 2013).

In another example, the Costa Rican health system implemented a formalized structure of community participation through community

health boards, which are formalized mechanisms for engagement with local actors at the facility level, representing a variety of interests through elected roles. A health board holds every hospital, clinic, and health area accountable. Communities elect board members, who provide feedback on the quality of health care services and promote preventative care activities. The Costa Rican Social Security Fund has developed guidelines for engagement with the health boards that have been established in law. The functions of the health boards include collaborating with health facility managers to prepare preliminary projects and budget modifications for the facilities in accordance with budget allocations and limits that the fund's board of directors sets; ensuring proper execution of the approved budget; issuing criteria, before negotiation, on the commitments of health facility management; issuing criteria for candidates for the position of facility manager, before appointment, provided that the appointment is competitive for a vacant position or in cases of manager substitutions lasting longer than one year; and providing opinions and recommendations in the definition of general priorities and policies of the facility in terms of investment, administrative contracting, and promotion and incentives for health center workers, in accordance with the fund's policies (Desai et al. 2022; Farnham et al. 2023; PHCPI n.d.d.).

In Fiji, the MHMS can establish a process for soliciting community input and incorporating it into planning and governance through establishment of similar community committees or boards. Through the annual budgeting process, the MHMS can allocate funds to community boards, potentially through their local facilties, to support regular, real-time realization of community-directed priorities. Involving communities as respected stakeholders in decision-making processes and enabling their operationalization can increase the health care system's ability to address community needs effectively.

5.2. Incorporate routine person-centered feedback and evaluation into PHC facilities.

A key component of improving quality of care is establishing a strong quality management infrastructure to promote realization of person-centered reforms. While implementing community boards can elevate community voices, Fiji can also adopt routine, person-centered evaluations at the facility level to address patient needs. For example, Fiji's subdivisional administrative structures could encourage use of passive feedback mechanisms, including the 157 hotline and suggestion boxes, by ensuring that necessary supplies are included in regular budgets. Facility leadership could be encouraged or required to report on their use of suggestion box feedback in annual reporting, such as including the number of comments received and examples of how suggestions informed service design or delivery. Fiji could also consider implementing a balanced scorecard system to evaluate the person centeredness of facility services, drawing insights from Afghanistan.

In 2002, the Afghan Ministry of Public Health, with input from other organizations, designed a basic package of health services to encompass all basic PHC needs. Evaluations were based on a balanced scorecard performance system that included a comprehensive list of performance indicators to measure program processes and outcomes (PHCPI n.d.c). For five years, data from patient observations, exit interviews, and provider interviews were collected from 25 facilities and incorporated into the balanced scorecard. There was evidence of consistent increases in patient and provider satisfaction, quality of services, and equity and improvements in service provision and the financial system over the study period. The tool enabled facilities to identify urgent needs for allocation of resources and innovations and helped facilities learn how to adapt based on findings from data. Although the balanced scorecard may be useful for performance

benchmarking and strategic management, the authors noted that its continued utility will depend on stakeholders' ability to adapt the balanced scorecard tool to changes in health care systems (Edward et al. 2015). Building on the example of balanced scorecards in Afghanistan, Fiji can improve its assessment of person-centered care using patient exit surveys and observations and should do so in alignment with the above recommendations regarding use of similar scorecards for facility management. Integrating the data from these activities into a scorecard would help facilities align with the health needs of the population while empowering patients to shape the health system.

5.3. Institutionalize inclusion of women's and girls' perspectives in facility health management decision making.

To bridge the gap in community involvement and feedback mechanisms, the health care system in Fiji can encourage inclusion of women's and girls' viewpoints in facility and population health decision-making processes by implementing targeted health education programs, ensuring that community centers and other health care facilities are recognized as "safe spaces," and establishing a minimum gender ratio for health committees and community committees such as village councils. Health programs could be designed with a focus on the health care needs and concerns of vulnerable populations, including women and children. These programs could not only provide information, but also actively seek feedback, fostering two-way communication between health care facilities and the community. Establishment of "safe spaces" within community centers and health care facilities can create environments where people with various gender identities feel comfortable expressing their opinions, concerns, and feedback without fear of judgment or discrimination. A minimum gender ratio for health committees or community committees ensures that decision-

making bodies reflect the diversity of the populations they serve. This gender balance can contribute to more comprehensive and inclusive decision-making processes, considering the unique perspectives and needs of the population. This approach aligns with efforts to increase community engagement and ensures that the voices of all members, especially women and girls, are not only heard, but also actively considered in shaping service delivery in Fiji's PHC system.

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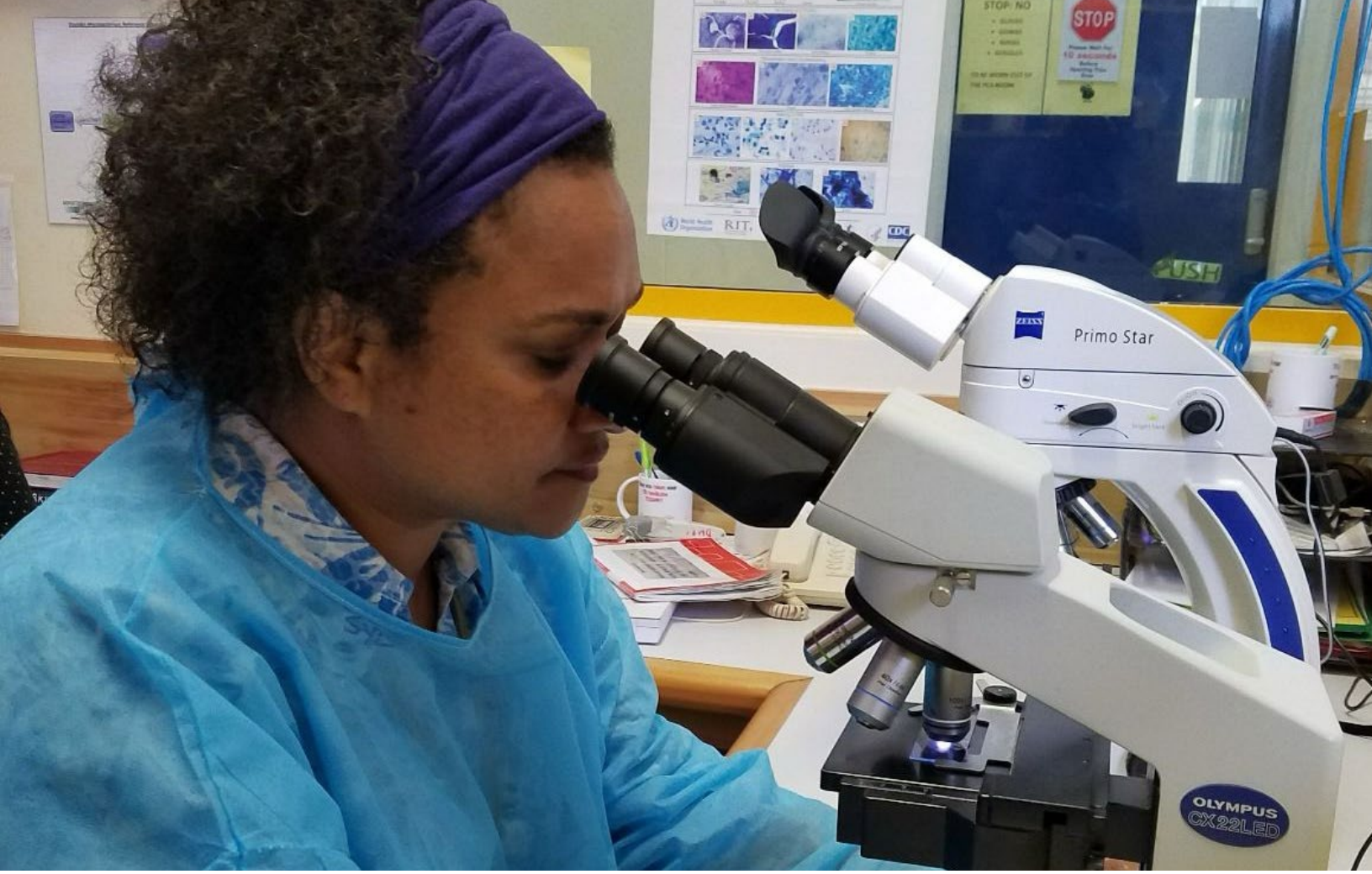
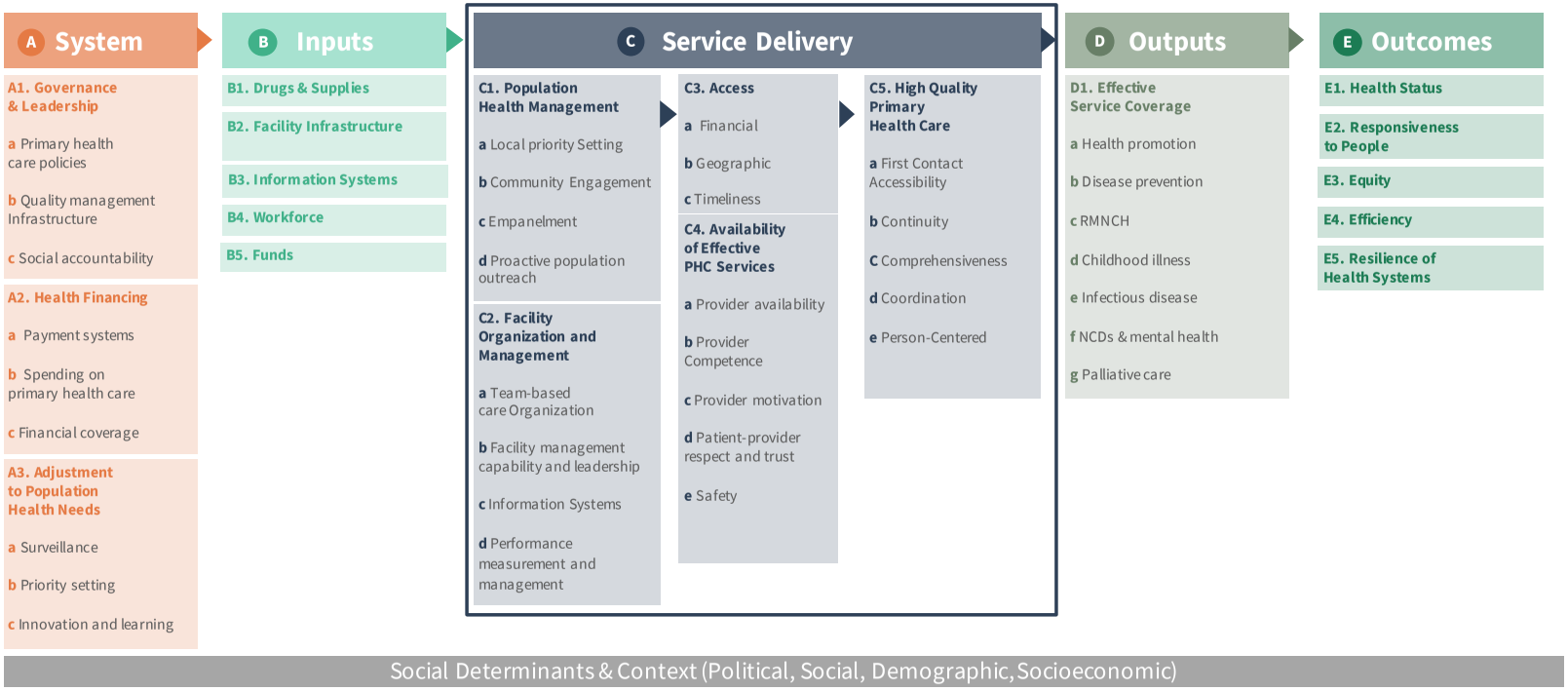


APPENDICES

APPENDIX A. PRIMARY HEALTH CARE PERFORMANCE INITIATIVE FRAMEWORK



Source: Veillard et al. 2017.

APPENDIX B. PERFORMANCE DOMAIN

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PERFORMANCE DOMAIN: DETAILED VITAL SIGNS PROFILE INDICATORS

Fiji	SCORE	PERCENTAGE	SOURCE	YEAR
ACCESS	91			
Financial				
Percentage of population that cannnot afford all medications prescribed*✧		9%	*HIES*	*2019-2020*
Geographic				
Perceived access barriers due to distance*		*No data available*		
QUALITY	79			
Comprehensiveness				
Avg. availability of 5 tracer RMNCH services		75%	*SARA Survey*	*2021*
Avg. availability of services for 3 tracer communicable diseases		61%	*SARA Survey*	*2021*
Avg. availability of diagnosis & management for 3 tracer NCDs		84%	*SARA Survey*	*2021*
Continuity				
DTP3 dropout rate*		1%	*MICS*	*2021*
Treatment success rate for new TB cases		54%	*WHO TB Country Profile*	*2022*
Person-Centeredness				
% of caregivers who were told sick child's diagnosis		*No data available*		
Provider competence				
Antenatal care quality score based on WHO guidelines		*No data available*		
Family planning quality score based on WHO guidelines		*No data available*		
Sick child quality score based on IMCI guidelines		*No data available*		
Adherence to clinical guidelines		*No data available*		
Diagnostic accuracy		*No data available*		
Provider availability				
% of family planning, ANC, and sick child visits over 10 minutes		*No data available*		
Provider absence rate*		*No data available*		
Safety				
Adequate waste disposal✣		82%	*SARA Survey*	*2021*
Adequate infection control✣		92%	*SARA Survey*	*2021*
SERVICE COVERAGE	51			
Reproductive, Maternal, Newborn and Child Health				
Demand for family planning satisfied with modern methods		51%	*MICS*	*2021*
Antenatal care coverage (4+ visits)		89%	*MICS*	*2021*
Coverage of DTP3 immunization		95%	*MICS*	*2021*
Care-seeking for suspected child pneumonia		68%	*MICS*	*2021*
Infectious diseases				
Tuberculosis cases detected and treated with success		30%	*WHO TB Country Profile*	*2022*
People living with HIV receiving anti-retroviral treatment		45%	*UNAIDS Country Factsheet*	*2021*
Children under 5 with diarrhea receiving ORS		54%	*MICS*	*2021*
Non-Communicable Diseases (NCDs)				
Prevalence of treatment among adults with hypertension**		35%	*UHC Global Monitoring Report*	*2023*

*Indicators where lower values are preferable were transformed before inclusion in the index. The modified indicator was defined as 100-X, where X is the original percentage shown in this table. **The indicator reflects modelled estimate for prevalence of treatment (taking medicine) for hypertension among adults aged 30-79 with hypertension, based on age-standardized estimates. For more details see Tracking UHC: 2023 Global Monitoring Report. ✧Country-specific (proxy) indicator, used in absence of globally comparable survey data. ✣ Waste collection is ultimately disposed of with general, household, and industrial waste without treatment as Fiji has not had a waste incinerator since 2019. Note: Summary scores for the domains of Access, Quality, and Coverage are calculated by taking the average of indicator values within each subdomain, and then taking the average across subdomain scores.

APPENDIX C: CAPACITY DOMAIN

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CAPACITY DOMAIN: DETAILED VITAL SIGNS PROFILE INDICATORS

Fiji	SCORE
GOVERNANCE	2.0
Governance and Leadership	1.6
Measure 1: Primary health care policies (1/2)	
Measure 2: Primary health care policies (2/2)	
Measure 3: Quality management infrastructure	
Measure 4: Social accountability (1/2)	
Measure 5: Social accountability (2/2)	
Adjustment to Population Health Needs	2.3
Measure 6: Surveillance	
Measure 7: Priority setting	
Measure 8: Innovation and learning	
INPUTS	2.2
Drugs and Supplies	1.3
Measure 9: Stock-out of essential medicines	
Measure 10: Basic equipment availability	
Measure 11: Diagnostic supplies	
Facility Infrastructure	1.3
Measure 12: Facility distribution	
Measure 13: Facility amenities	
Measure 14: Standard safety precautions and equipment	
Information Systems	3.3
Measure 15: Civil Registration and Vital Statistics	
Measure 16: Health Management Information Systems	
Measure 17: Personal care records	
Workforce	3.0
Measure 18: Workforce density and distribution	
Measure 19: Quality assurance of primary health care workforce	
Measure 20: Primary health care workforce competencies	
Measure 21: Community health workers	
Funds	2.0
Measure 22: Facility budgets	
Measure 23: Financial Management Information System	
Measure 24: Salary payment	
POPULATION HEALTH AND FACILITY MANAGEMENT	1.6
Population Health Management	1.8
Measure 25: Local priority setting	
Measure 26: Community engagement	
Measure 27: Empanelment	
Measure 28: Proactive population outreach	
Facility Organization and Management	1.4
Measure 29: Team-based care organization	
Measure 30: Facility management capability and leadership	
Measure 31: Information system use	
Measure 32: Performance measurement and management (1/2)	
Measure 33: Performance measurement and management (2/2)	

APPENDIX D. RECOMMENDATIONS BASED ON THE FIJI VITAL SIGNS PROFILE

Recommendation	Resources required, from low (+) to high (+++)	Difficulty of execution, from low (+) to high (+++)	Potential impact, from low (+) to high (+++)	Time horizon from impact (short, medium, or long term)	Vital Signs Profile domains and subdomains addressed
1: Implement a people-centered model of care focused on delivering comprehensive PHC at the community level by updating the package of health services and redefining the next generation of PHC personnel.					
1.1 Define and develop new service package and delivery framework for integrated PHC.	++	+++	+++	Long term	Access, quality, coverage, capacity Governance and leadership
1.2 Determine necessary workforce cadres and locations for reallocation of human resources.	++	++	++	Medium term	Access, quality Workforce Facility organization and management
1.3 Redefine the next generation of PHC personnel and strengthen their competencies.	++	++	++	Long term	Capacity, access, equity, coverage Workforce, facility organization and management, population health management
Recommendation 2: Enhance community-based services by bolstering proactive population outreach efforts and fortifying the Community Health Worker (CHW) program.					
2.1 Expand comprehensive service delivery beyond health facilities through integrated, proactive population outreach in rural settings.	+	++	+++	Medium term	Access, equity, coverage Population health management
2.2 Extend proactive population outreach practices to urban and peri-urban areas to reach the growing urban population.	++	++	+++	Short term	Access, quality, coverage Adjustment to population health needs Population health and facility management
2.3 Extend the Community Health Worker model by recruiting, training, and overseeing CHWs in urban and peri-urban areas.	++	++	+++	Short term	Access, equity, quality, coverage Workforce Population health management
2.4 Fortify the Community Health Worker model and implement task shifting to build on successes of the existing CHW program.	+	+	++	Medium term	Access, quality Workforce Population health management

Recommendation	Resources required, from low (+) to high (+++)	Difficulty of execution, from low (+) to high (+++)	Potential impact, from low (+) to high (+++)	Time horizon from impact (short, medium, or long term)	Vital Signs Profile domains and subdomains addressed
3: Strengthen governance and leadership for PHC for effective prioritization and implementation of comprehensive primary health care as part of a broader effort to enhance accountability for achieving collective health system results.					
3.1 Improve coordination and clarity on PHC across MHMS entities at national and subnational levels by establishing PHC leadership position.	+++	+++	+++	Short term	Access, quality, coverage Governance and leadership
3.2 Establish accountability mechanisms to help ensure that policies, strategies, and plans are translated into action and achieve desired outcomes.	++	++	++	Medium term	Quality Governance and leadership Adjustment to population health needs
3.3 Strengthen collaboration between MHMS and other important PHC actors and stakeholders through a designated PHC committee and annual multisectoral meeting.	+	+	++	Short term	Governance and leadership Adjustment to population health needs
4: Leverage the recently approved digital health strategy to enable regular analysis and application of information on PHC capacity, performance, and outcomes at facility, subnational, and national levels.					
4.1 Enable facility-level analysis of performance and outcome data to coordinate care, monitor performance, and drive effective management.	++	++	+++	Short term	Quality, coverage, access Information systems Population health and facility management
4.2 Drive real-time data collection and use of information systems for performance improvement at all levels by digitalizing nursing station data collection, reporting, and analysis and establishing accessible, PHC-oriented dashboards.	+++	+++	++	Long term	Quality, coverage, access Information systems Population health and facility management
4.3 Integrate and strengthen data platforms for efficient use of information to deliver continuous, person-centered PHC.	++	++	++	Long term	Quality, coverage, access Information systems Governance and leadership

Recommendation	Resources required, from low (+) to high (+++)	Difficulty of execution, from low (+) to high (+++)	Potential impact, from low (+) to high (+++)	Time horizon from impact (short, medium, or long term)	Vital Signs Profile domains and subdomains addressed
5: Strengthen and standardize systems for regular community engagement in PHC priority setting and accountability.					
5.1 Standardize and integrate community engagement into routine population health management practices.	+	++	+++	Short term	Coverage, quality Governance and leadership Population health and facility management Funds
5.2 Incorporate routine person-centered feedback and evaluation into PHC facilities.	+	++	++	Short term	Access, quality, equity Population health and facility management
5.3 Institutionalize inclusion of women's and girls' perspectives in facility health management decision-making.	++	++	++	Medium term	Capacity, access, equity Population health and facility management

Note: CHW = community health worker; PHC = primary health care.

APPENDIX E. IMPLICATIONS OF THE RECOMMENDATIONS FOR STAKEHOLDERS

Recommendation	National government and health authorities	Regional or divisional health authorities	Service delivery providers	Academia	Patients and citizens
1: Implement a people-centered model of care focused on delivering comprehensive PHC at the community level by updating the package of health services and redefining the next generation of PHC personnel.					
1.1 Define and develop new service package and delivery framework for integrated PHC.	F, E, P, M, D	E, P, D, M	P, I	E, P, I	P, I
1.2 Determine necessary workforce cadres and locations for reallocation of human resources.	F, E, M, D	E, M, P	P	P, D	I
1.3 Redefine next generation of PHC personnel and strengthen their competencies.	F, E, M, P, D	E, P, D, M	P, I	P, D	P, I
2: Enhance community-based services by bolstering proactive population outreach efforts and fortifying the Community Health Worker (CHW) program.					
2.1 Expand service distribution by health facilities, including through proactive population outreach.	F, E	E, M, P, I	P, I	I	P, E
2.2 Extend proactive population outreach practices to urban and peri-urban areas to reach the growing urban population.	F, E	E, M, P, I	P, I	I	P, E
2.3 Extend the Community Health Worker model by recruiting, training, and overseeing CHWs in urban and peri-urban areas.	F, E, D	F, E, M, D	P, M, I	I	P, E
2.4 Fortify the Community Health Worker model and implement task shifting to build on the successes of the existing CHW program.	F, E, M, D	M, P, D	P, M, I	I	I
3: Strengthen governance and leadership for PHC for effective prioritization and implementation of comprehensive primary health care as part of a broader effort to enhance accountability for achieving collective health system results.					
3.1 Improve coordination and clarity on PHC across MHMS entities at national and subnational levels by establishing PHC leadership position	E, M, P, D, F	E, P, D, M, F	P, I	I	I
3.2 Establish accountability mechanisms to help ensure that policies, strategies, and plans are translated into action and achieve desired outcomes.	E, M, P, D, F	E, P, D	P, I	P, I	P, I
3.3 Strengthen collaboration between MHMS and other important PHC actors and stakeholders through a designated PHC committee and annual multisectoral meeting.	E, M, P, D, F	E, P, D, M	P	P, I	I

Recommendation	National government and health authorities	Regional or divisional health authorities	Service delivery providers	Academia	Patients and citizens
4: Leverage the recently approved digital health strategy to enable regular analysis and application of information on PHC capacity, performance, and outcomes at facility, subnational, and national levels.					
4.1 Enable facility-level analysis of performance and outcome data to coordinate care, monitor performance, and drive effective management.	F, E, D	E, M, P, D	P, D	P, I	I
4.2 Drive real-time data collection and use of information systems for performance improvement at all levels by digitalizing nursing station data collection, reporting, and analysis and establishing accessible, PHC-oriented dashboards.	E, M, F, D	E, M, P, D	P, M	P, I	I
4.3 Integrate and strengthen data platforms for efficient use of information to deliver continuous, person-centered PHC.	E, M, F, D	P, D	P, I	I	I
5: Strengthen and standardize systems for regular community engagement in PHC priority setting and accountability.					
5.1 Standardize and integrate community engagement into routine population health management practices	F, I	E, M, F, D	E, P	I	E, M, D
5.2 Incorporate routine person-centered feedback and evaluation into PHC facilities.	F, I	E, M, D	P, I	P, I	E, M, D, P
5.3 Institutionalize inclusion of women's and girls' perspectives in facility health management decision-making.	F, E	E, M, D	P, I	P, I	E, M, P, D

Note: F=provide financing or financial incentives, E=establish strategic direction, norms, and policies, M=manage program, P=participate in implementation of program or support it, I=stay informed on program activities, D=make informed or strategic decisions, CHW = community health worker; PHC = primary health care.

APPENDIX D. PROGRESSION MODEL PARTICIPANTS

KEY INFORMANTS

Name	Organization	Title
Mrs. Muniamma Gounder	MHMS	Former Head of Policy and Planning
Dr. Luse Buinimasi	MHMS	National Tuberculosis Control Officer
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Dr. Alisha Sahukhan	MHMS	Head of Health Protection
Dr. Varanisese Smith	MHMS	Head of Health Information Unit
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Dr. Jun Gao	World Health Organization	Team Leader IER
Mr. Joe Fuata	MHMS	Director of Recruitment, Department of Human Resources
Mr. Idrish Khan	MHMS	Head of Finance and Asset Management

Note: MHMS = Ministry of Health and Medical Services.

VALIDATION WORKSHOP PARTICIPANTS (OCTOBER 3-5, 2023)

Name	Title
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Varanisese Smith	Head of Research, Digital Health Innovations
Idrish Khan	Head of Finance
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Dr. Josese Turagava	Clinical Service Network Lead : HOD Surgery
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Name	Title
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Margareta Norris Harrit	World Bank
Manuela Villa Uribe	World Bank
Lucy Hartshorn	World Bank
Awa Diallo	World Bank

Source: October 3-5, 2023, Validation Workshop Participants list.

APPENDIX E. PROGRESSION MODEL DOCUMENTS REVIEWED

1. National Strategic Plan 2020-2025
2. Annual Operational Plan 2022-2023
3. Annual Operational Plan 2019-2020
4. National Wellness Policy
5. Noncommunicable Disease Strategic Plan 2015-2019
6. World Health Organization Package of Essential Noncommunicable Disease Interventions for Primary Health Care
7. Fiji Health Sector Support Program: End of Program Evaluation
8. Fiji Islands Health System Review
9. Medicines Shortages in Fiji: A Qualitative Exploration of Stakeholder Views
10. Barriers for Health Promotion and Disease Prevention in Fiji
11. Situational Analysis of Children in Fiji
12. Fiji Respiratory Guidelines
13. Diabetes Management Guidelines
14. Reproductive Health Policy
15. Medical Services Pacific
16. MHMS Wellness Website
17. MHMS Family Health Website

18. World Health Organization Fiji Country Cooperation Strategy 2018-2022
19. Health Information System–Clinical Information System Strategy 2016-2020
20. Strategic Plan 2016-2020 Executive Version
21. The Evolution of Primary Health Care in Fiji: Past, Present and Future
22. Health Information Systems in the Pacific at a Glance
23. Reproductive Family Health Association of Fiji
24. Ministry of Women, Children and Poverty Alleviation Website
25. The Warwick Principles: Best Practices for Engaging Men and Boys in Preventing Violence Against Women and Girls in the Pacific
26. Fiji Civil Society Index Report
27. Fiji Role Delineation Project draft report
28. Fiji Specialised Clinical Services and Visiting Team Manual
29. TQM Project Newsletter
30. Pacific Public Health Surveillance Network IPC Guidelines
31. COVID-19 Intra Action Review Report (phase 1)
32. Service Availability and Readiness Assessment
33. Fiji National Disaster Management Officer Cluster System Website
34. Fiji Health and Nutrition Cluster Terms of Reference
35. Fiji Health and Nutrition Cluster Contact List
36. MHMS website Site Archives
37. Health Technology Assessment
38. Terms of Reference for the Safety and Protection Cluster

39. Health Status Report

40. Communicable Disease Surveillance and Outbreak Response Guidelines

41. World Health Organization Fiji Country Cooperation Strategy

42. Pacific Syndromic Surveillance System W1 2023 (Jan 1-Jan 7)

43. Fiji Country Gender Assessment Policy Briefs

44. Fiji Essential Medicines List 4th Edition

45. Health Facility Readiness and Service Availability Assessment

46. MHMS Website Interactive Map

47. Master Facility List

48. Mid-year report

49. Perceptions of Healthcare Workers Towards Childhood Immunization and Immunization Services in Fiji: A Qualitative Study

50. Presentation: Status of CRVS in Fiji. Inequality Assessment for the Civil Registration and vital Statistics in Fiji Workshop

51. Fiji Vital Statistics Report 2012-2017

52. Mortality Workflow

53. HIU Public Health Information System form

54. HIU Hospital Primary Health Information System form

55. HIU Primary Health Information System Statistical Submission Process Summary

56. HIU Primary Health Information System Submission Process

57. HIU Process Mapping for NCDs

58. HIU Overview of Changes to Three Registers Following a Discussion with DONs, SDNM, SDHNM, and DHIO Eastern
59. Health Worker Density by Country
60. State of the Pacific's RMNCAH Workforce Report
61. SOP for In-Service Training
62. List of programs offered as in-service training
63. Fiji National Service Delivery Protocol for Responding to Cases of Gender Based Violence
64. Women's Plan of Action 2009-2019
65. Fiji National University MBBS Degree Description
66. Fiji National University Bachelor of Health Promotion degree description
67. Fiji National University Bachelor of Nursing degree description
68. Community Health Worker Manual: Core Competencies
69. Corporate Plan 2017-2018
70. Community Health Worker Policy
71. General Orders
72. Terms and Conditions of Employment for Government Wage Earners
73. People with Concerns on Health Services in Fiji Encouraged to Call Ministry of Health Helpline
74. Fiji Health Sector Improvement Program
75. Fiji National Gender Policy for the Republic
76. Fiji National University Bachelor of Health Services Management Degree Description

77. A Review of Health Leadership Management Capacity in Fiji

78. Health Status Report 2016


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